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SECRETARY OF THE AIR FORCE**

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Aerospace Medicine

DUTY LIMITING CONDITIONS



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This publication implements Air Force Policy Directive (AFPD) 48-1, *AEROSPACE & OPERATIONAL MEDICINE ENTERPRISE (AOME)*. This instruction describes requirements for medical profiling on members with duty or mobility restrictions, case management of mobility restricted Airmen, and processes for improving medical deployability. This publication applies to all civilian employees and uniformed members of the Regular Air Force (RegAF), Air National Guard (ANG), Air Force Reserve (AFR). This instruction requires the collection and/or maintenance of information protected by the Privacy Act of 1974, authorized by Title 10 United States Code, Section 9013, *Secretary of the Air Force*. System of records notice F044 F AF SG E, Medical Record System, applies, and can be found at <http://dpclo.defense.gov/Privacy/SORNs.aspx>. Ensure all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Instruction (AFI) 33-322, *Records Management and Information Governance Program*, and disposed of in accordance with the Air Force Records Disposition Schedule located in the Air Force Records Information Management System. Refer recommended changes and questions to the office of primary responsibility (OPR) listed above; route AF Forms 847, *Recommendation for Change of Publication*; through the appropriate functional chain of command. This publication may be supplemented at any level, but all supplements must be routed to the OPR listed above for coordination prior to certification and approval. 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 requestor's commander for non-tiered compliance items.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. It replaces AFI 10-203, *Duty Limiting Conditions*. Major changes include the inclusion of Airman availability management processes and the inclusion of Airmen medical readiness optimization (AMRO).

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Chapter 1

GENERAL PROVISIONS

1.1. Overview. This publication establishes instructions for the documentation and administrative management of Airmen with medical conditions that may impact their ability to perform their military duty. These procedures have been developed to ensure maximum utilization and readiness of personnel, while preserving their health and minimizing risk of further injury or illness. This publication describes appropriate courses of action for the Disability Evaluation System (DES) and Air Reserve Component (ARC)-specific non duty-related disability evaluation system (NDR-DES) pre-screening disposition when individuals have medical conditions potentially affecting their continued fitness for military service or deployability in the AF, as outlined by the standards per AFI 48-123, *Medical Examinations and Standards*.

1.1.1. This publication provides the requirements for communicating medical recommendations, return to duty instructions, and potentially unfitting conditions to commanders. This publication will provide commanders the opportunity to optimally utilize Airmen under their command. Refer to AFI 41-200, *Health Insurance Portability and Accountability Act (HIPAA)*, for guidance on HIPAA compliant communication for commanders.

1.1.2. Commanders (CCs) may consult with the medical unit's senior profile officer (SPO) to maximize use of personnel with duty limiting conditions (DLCs). An assessment based on operational risk of personnel assigned to a unit is critical to maintaining unit readiness at the highest degree possible.

1.1.3. Purpose of AF Form 469, *Duty Limiting Condition Report*. The AF Form 469 is used to describe physical limitations and recommend Duty Restrictions (DR) and Mobility Restrictions (MR) to the CC when there is a potential risk to an Airman's health, safety and well-being, the safety of the mission, or the ability of the Airman to effectively accomplish the mission. Additionally, the AF Form 469 is used to convey limitations related to the AF Fitness Program as well as fitness assessment exemptions (FAE). In general, the AF Form 469 will describe an Airman's limitations and FAE/clearance.

1.1.4. Purpose of AF Form 422, *Notification of Air Force Member's Qualification Status*. The AF Form 422 is used to communicate medical clearances and resulting qualification between the medical field and Air Force Personnel Center (AFPC). It shall be used for, but is not limited to, the following medical processes: retraining, permanent change of station (PCS), professional military education (PME), etc. The AF Form 422 describes what an Airman is qualified to do based on medical assessment, requirements in the Air Force Officer Classification Directory and Air Force Enlisted Classification Directory, and other similar guidelines (unless specifically directed otherwise, as in [paragraph 3.3.2.1](#) of this publication).

1.2. Physical Profile System to include Physical Profile Serial Chart (PULHES). The physical profile system classifies individuals according to physical/functional abilities and long-term availability for worldwide duty in accordance with (IAW) AFI 36-2101, *Classifying*

Military Personnel (Officer and Enlisted), Air Force Officer Classification Directory and Air Force Enlisted Classification Directory.

1.2.1. Applicability. The physical profile system applies to the following categories of personnel:

1.2.1.1. Applicants for appointment, enlistment, and induction into military service.

1.2.1.2. Officer categories within the Regular Air Force (RegAF) and ARC:

1.2.1.2.1. USAF Academy and Reserve Officers Training Corps cadets.

1.2.1.2.2. Students in the Uniformed Services University of Health Sciences and Health Professions Scholarship Program.

1.2.2. PULHES determinations are descriptions of transient or permanent limitations to functioning which are used for establishing suitability for career fields or Air Force Specialty Code (AFSC). A PULHES determination can be established on an AF Form 422, or other forms as directed. Once a PULHES determination is established, it is considered current unless updated during appropriate medical reviews.

1.2.3. See [Attachment 2](#) for PULHES chart.

1.3. Duty Limitations. Duty limitations will be entered on the AF Form 469. **(T-2)** Duty limitations are a type of profile which will indicate what the member cannot do based on his/her current occupational duties with resultant mobility and/or fitness restriction (FR) if appropriate.

1.3.1. The maximum allowable duration of the AF Form 469 following review in lieu of (RILO) of medical evaluation board (MEB) will be dependent upon the date for a follow up RILO as indicated on the FL4 from AFPC/Medical Retention Standards Branch (DP2NP).

1.3.1.1. The expiration date for the profile will be the same as the date for follow up required on the FL4. **(T-2)**

1.3.1.2. For any other duty or mobility restrictions assignment availability codes (AACs) 31, 37, or 81, the maximum allowable duration of the AF Form 469 is 365 days.

1.3.1.3. Fitness restrictions will be up to 365 days, unless the condition has been determined to be permanent, for which indefinite profiles can be created. (See [Chapter 3](#) of this publication for further guidance.) **(T-2)**

1.3.2. A duty-limiting condition (DLC) is the medical condition which impairs and/or prevents an Airman from performing at least some requirements of military service and/or duties expected to be a part of his/her air force specialty code (AFSC) and/or current assignment. DLCs may also affect additional duties, military details, volunteer service, recreational activity, and/or activities of daily living.

1.3.3. DLCs annotated on an AF Form 469 must be reviewed for appropriateness and accuracy at every appointment/clinical encounter between the Airman and a provider. **(T-2)** Additionally, the AF Form 469 must be re-validated and renewed or revised, as appropriate, at each preventive health assessment (PHA) at a minimum. **(T-1)** See [Chapter 3](#) of this publication for further guidance.

1.3.4. Three circumstances trigger special review: 1) a DLC that restricts mobility for 365 consecutive days; 2) any DLC that restricts mobility for 365 cumulative days in a three-year

period; or 3) a DLC that may be considered unfitting for continued military service. If one or more of these circumstances exists, an Airman must undergo a review by the airmen medical readiness optimization (AMRO) board. **(T-1)** That board will determine the necessity of referring the case to the Air Force Personnel Center, Medical Retention Standards Branch (AFPC/DP2NP), recommending for or against the use of an Initial Review In Lieu Of (IRILO) MEB referral to headquarters AFPC Medical Retention Standards Branch (DP2NP) or the appropriate ARC, Chief of Aerospace Medicine (SGP). The ANG shall refer to the ANG/SGP. The AFR will use AFRC/Medical Operations Division (SGO), IAW AFI 48-123 and Air Force Manual (AFMAN) 41-210, both of which contain more details.

1.3.5. Aeromedical services information management system (ASIMS) can track multiple DLCs simultaneously with separate expiration dates; however, an Airman may only have one active AF Form 469 at a time.

1.4. Special Considerations.

1.4.1. Air Reserve Component (ARC)-unique issues. For ARC Airmen, refer to AFI 48-123 and AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members*.

1.4.1.1. For purposes of this publication, the term military treatment facility (MTF) will be used to refer to all RegAF and ARC medical units with the aerospace medicine mission set, unless otherwise specified as RegAF MTF for RegAF, reserve medical unit (RMU) for AFR, or guard medical unit (GMU) for ANG units.

1.4.1.2. Medical standards management element (MSME) is a RegAF element. The function of the MSME is executed by a 4N0F in Air Force Reserve and a full-time health technician for the ANG, or otherwise as directed. For the purpose of this publication, the term MSME will be used to include the RegAF and ARC functions. (See [paragraph 2.10](#) of this instruction for more details.)

1.4.2. Refusal to obtain medical evaluation or treatment. The AMRO board will refer Airmen who have been evaluated as having potentially disqualifying defects and who refuse recommended further medical evaluations or treatment for those defects. The referral will be to AFPC/DP2NP, ANG/SGP or AFRC/SGO as applicable. The referral will be for IRILO or Non Duty Related Disability Evaluation System (NDR-DES) determination IAW AFMAN 41-210, *TRICARE Operations and Patient Administration*. AFPC/DP2NP, ANG/SGP or AFRC/SGO will consider the Airman's retainability in the service with the medical condition in its current state. AFPC/DP2NP, ANG/SGP or AFRC/SGO will also consider the probability of progression of disease or worsening of the medical condition without the necessary evaluation or recommended medical treatment. Depending on the final disposition of the case, the Airman may not be eligible for military disability payment and may be subject to involuntary separation under AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*; AFI 36-3208, *Administrative Separation of Airmen*; AFI 36-3209, or AFI 48-123.

1.4.2.1. Second opinion. Any Airman with a potentially disqualifying condition has the option of seeking a second opinion to explore treatment options. The PCM team, through its referral processes, must arrange for a consultant to provide the second opinion. **(T-1).**

Exception: An ARC member who is seeking a second opinion during a NDR-DES determination for a condition found not in the line of duty (NILOD). **(T-1).**

1.4.2.2. When both medical opinions agree and the Airman refuses all treatment options provided, an IRILO must be accomplished. If the medical opinions differ, the Airman may choose one of the treatment options given. Further medical opinions will only be considered upon appeal to the MTF Chief of the Medical Staff (SGH) who will determine whether the evaluation or treatment is a covered benefit which is deemed by the SGH to be medically necessary.

Chapter 2

GUIDANCE

Section 2A—ROLES AND RESPONSIBILITIES

2.1. The Chief of Staff of the Air Force. Establishes AF personnel readiness goals and standards and is responsible for force readiness, including medical readiness, to ensure the AF can meet national requirements for defense of the country.

2.2. Air Force Surgeon General (AF/SG). Establishes medical standards and procedures for recommending duty limitations.

2.3. Major Command (MAJCOM)/ Chief of Aerospace Medicine (SGP), ANG/SGP or Air Force Reserve/Chief, Medical Operations Division (AFRC/SGO).

2.3.1. Acts as liaison between the military treatment facility and Air Force Medical Readiness Agency (AFMRA).

2.3.2. Provides MAJCOM trend analysis using aggregated data with personal identities removed on duty limitations and reports to MAJCOM/CC as requested.

2.3.3. Acts as liaison between MTFs and the Combatant Command (COCOM)/SG for DLC issues that might impact the COCOM mission.

2.3.4. Identifies total force enterprise medical manpower requirements to accomplish requirements within this AFI and incorporates them into the business case analysis and Flight and Operational Medicine Program, for additional requirements.

2.3.5. ANG/SGP or AFRC/SGO reviews all RILO/NDR-DES cases as required by AFMAN 41-210.

Section 2B—PROCEDURES AND GUIDELINES

2.4. Military Treatment Facility (MTF)/Commander (CC). **Note :** MTF/CC for ARC medical units may delegate these responsibilities to SGP or SGH as deemed appropriate.

2.4.1. Will ensure timely submission of RILOs to AFPC/DP2NP, ANG/SGP or AFRC/SGO as applicable. **(T-2).**

2.4.2. Develops policies and/or guidance to ensure that a process for expeditious referrals (e.g., within 72 hours) is available for providers when such determination is necessary for an Airman to avoid delay or to prevent failure of a mobility mission, IAW AFI 44-176, *Access to the Care Continuum*, and AFMRA/CC and Department of Defense (DoD)/Defense Health Agency (DHA) guidance.

2.4.3. Will ensure ARC Airmen with a non-duty-related medical issue existing prior to service/NILOD are directed to follow-up with their civilian providers. **(T-2).** Any delays in Airmen providing civilian medical records that affect the ability to establish the individual medical readiness requirements will be reported to the Airman's CC IAW AFI 10-250, *Individual Medical Readiness*.

2.4.4. Will ensure ASIMS access is given to required personnel and ensure procedures are established to accomplish needed ASIMS tasks even when the system is down. **(T-2).**

2.5. Military Treatment Facility/Chief of Aerospace Medicine (SGP).

2.5.1. Will advise MAJCOM/SGP, ANG/SGP or AFRC/SGO for cases in which a unit CC and the next higher CC choose to non-concur with a MR recommendation (See [paragraph 3.4.2](#)). **(T-2).**

2.5.2. Will report aggregate profile, DLC, and deployment availability statistics (using aggregated data with personal identities removed) to MAJCOM/SGP, ANG/SGP or AFRC/SGO as requested. **(T-2).**

2.5.3. Will ensure profiling and duty limitation standards are met. **(T-1).**

2.5.3.1. Will monitor the AF Form 422 and AF Form 469 processes; ensure compliance for timely completion by staff. **(T-1).**

2.5.3.2. Will monitor quality of DLC determinations, fitness assessment exemptions (FAE), and applied medical standards as documented on AF Form 422 or AF Form 469. **(T-1).**

2.5.4. Will serve as chairman of the deployment availability working group (DAWG) and AMRO board. **(T-2).** Alternatively, the SGH may serve as the DAWG and/or AMRO board chairman if the MTF/CC determines that the SGP is not available or capable of overseeing these functions. In these instances, the MTF/CC will advise the MAJCOM/SGP, ANG/SGP or AFRC/SGO of the change in DAWG/AMRO board chair.

2.5.5. Will share responsibility with the SGH for training all providers and answering questions related to the appropriate completion of profiles and duty (including fitness) limitations and the MEB process. **(T-2).** The SGP will ensure that all primary care managers (PCM) understand the purpose of the AMRO board and the processes used by the AMRO board to meet its mission. **(T-2).**

2.5.6. Will ensure the clinical review and quality control of all documents and packages sent to AFPC/DP2NP, ANG/SGP or AFRC/SGO as applicable for RILOs. **(T-2)**

2.5.6.1. For ARC facilities, the AD MTF is responsible for quality control and completion of IRILOs, NDR-DES determinations, and MEBs for those ARC members whose medical care and/or individual medical readiness services are provided by the MTF (such as individual mobilization augmentees (IMAs), Active Guard and Reserve or voluntary limited period of active duty members). The MTF is also responsible for MEB/integrated disability evaluation system cases for ARC personnel with duty-related conditions. RMU/GMU SGP will be responsible for quality control and completion of cases for traditional reservists/guardsmen, to include IRILOs as well as non-duty-related NDR-DES determinations. **(T-2)**

2.5.7. Will ensure, with assistance of the MSME, a method is in place for trigger events to be reported to the MSME and/or AMRO board. **(T-2)**

2.5.8. Will ensure all open AF Forms 422 and AF Forms 469 are finalized by the close of business (COB) of the last day of the UTA unless specific circumstances prevent it. (This requirement is for the RMU/GMU SGP.) **(T-2)**

2.5.9. Will serve as the MTF senior profile officer (SPO) IAW AFI 48-101, *Aerospace Medicine Enterprise*. In rare instances where no credentialed flight surgeon (FS) is assigned to the MTF, the senior credentialed physician may serve as the SPO. (T-2) Waiver requests from the ANG for this requirement, if the SPO is not a FS, must be submitted to the National Guard Bureau SGP. (T-2)

2.5.10. Will serve as the installation's final medical authority on DR and/or MR and the application of medical standards as it applies to AF Form 422 and AF Form 469. (T-1)

2.5.11. Will coordinate with MSME to report profile, DLC, and deployment availability statistics to the DAWG. (T-1)

2.5.12. Will be available to discuss and consider commander's concerns and questions regarding Airmen profile recommendations and concerns about unit health trends.

2.5.13. Shall be appointed in writing by the MTF/SGP. (T-1).

2.6. Military treatment facility (MTF)/Chief of the medical staff (SGH).

2.6.1. Will share responsibility with the SGP for training all providers (see [Paragraph 2.5.7](#)) to ensure all AD patients (including those on active duty orders) are evaluated for duty/mobility/fitness restrictions at each visit. (T-2). that could be confidential, privileged and protected from disclosure IAW 10 USC § 1102.

2.6.2. Along with the SGP, will ensure providers utilize current IRILO narrative summary (NARSUM) templates for medical and mental health (MH)/traumatic brain injury conditions. (T-2).

2.6.3. Will assist SGP to monitor the quality of DLC determinations, FAE, and applied medical standards as documented on AF Forms 422 or AF Forms 469. (T-2). Will ensure training is provided to the professional staff and teams to address any gaps of application of medical standards. (T-2).

2.6.4. Will attend the DAWG and AMRO board. (T-2).

2.7. Clinic providers (including specialty providers within the military treatment facility (MTF). Note: ARC physical examination sections will ensure these actions are accomplished in an appropriate manner for ARC members seen by civilian providers.

2.7.1. Will determine if conditions identified during every patient encounter and special purpose examination, specifically PHAs, affect the Airman's ability to: 1) deploy, 2) perform the duties of the assigned AFSC, 3) meet retention medical standards, 4) complete the fitness assessment (FA). (T-1)

2.7.1.1. The provider will use ASIMS generated AF Form 469 to communicate duty and functional limitations and FAE to the unit commander. (T-1).

2.7.1.2. On initiation of an AF Form 469, providers must ensure Airmen understand the DLC process. (T-2).

2.7.1.3. ARC medical units will coordinate with AD MTFs or triple option benefit plan (TRICARE) to obtain follow-up and/or consultations for duty-connected issues and any line of duty (LOD) determination in progress IAW AFI 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay*. (T-

2). ARC Airmen with non-duty connected issues will be directed to see their civilian provider for additional evaluation with explicit instructions to provide clinical information to the medical unit in a timely manner. **(T-2).**

2.7.1.4. When initiating an AF Form 469, provider will document in the medical note that a profile was created, and to refer to ASIMS.

2.7.1.5. An AF Form 469 is not required for conditions that are reasonably expected to resolve within 72 hours.

2.7.2. Will evaluate the continued need for, and the appropriateness of, the Airman's AF Form 469 at every face-to-face clinical encounter. All special purpose medical examinations and PHAs must include a review of existing limitations.

2.7.3. Will refer a case to the AMRO board for IRILO consideration when it is determined that an Airman may not meet retention standards IAW AFI 48-123 or is mobility restricted for a period that will, or is reasonably anticipated to, exceed 365 days. **(T-1).** If a case is referred by AMRO board for IRILO, the provider will meet all requirements outlined in this AFI for IRILO submission. **(T-1).**

2.7.4. Will assess the impact of medical conditions or functional limitations on an Airman's ability to participate in unit physical fitness training as well as the impact on the FA. **(T-1).** FR and/or FAE will be described by the provider on the AF Form 469 and will be processed IAW this publication and AFI 36-2905, *Fitness Program*. **(T-1).**

2.7.5. Will complete medical examinations required for assignment, retraining, or deployment. **(T-1)** Additionally, all providers will assist MSME by making recommendations for patients with medical conditions that may affect assignment, retraining, or deployment at visits where such conditions are discussed. **(T-1).**

2.7.6. Will not be required to notify commanders regarding those Airmen who self-refer or are medically referred for MH care or substance misuse education unless disclosure is authorized in Department of Defense Instruction (DoDI) 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*. **(T-0).**

2.8. Clinical consultants/medical specialists.

2.8.1. Military medical specialists will provide timely, complete, and concise summaries (IRILO narrative summaries or clinical encounter documentation) regarding an Airman's clinical status, including specific functional limitations and qualification for continued military service or deployability **(T-1).**

2.8.1.1. Clinical consultations on ARC Airmen must be completed within 30 days if the Airman is receiving care for a LOD condition; otherwise they must be done within 90 days. **(T-2).**

2.8.1.2. If a clinical consultant in an MTF determines an Airman requires a duty limitation, the consultant will initiate an AF Form 469 (or equivalent form specific for the service of the consultant), and will document this duty limitation in the Airman's medical record. **(T-2).**

2.8.2. AF providers will render the final authority on deployment, medical retainability, and physical limitation recommendations made from civilian (non-MTF) clinical consultants. **(T-**

1). **Note:** ARC Airmen will ensure the ARC medical unit receives civilian provider medical documentation within 90 days of the encounter. **(T-1).**

2.9. Profile officer (PO).

2.9.1. Shall be a FS, aeromedical physician assistant or aeromedical nurse practitioner with appropriate credentials in aerospace medicine, and be familiar with these publications: AFI 48-123; AFI 48-149, *Flight and Operational Medicine Program (FOMP)*; AFI 44-170, *Preventive Health Assessment*; and AFI 36-2905. If no FS, aeromedical physician assistant, or aeromedical nurse practitioner is assigned, the Medical Group (MDG)/CC appoints the most qualified physician. **(T-2).**

2.9.2. Will receive formal training on his/her duties by the SGP/SPO. **(T-2).**

2.9.3. Will perform final review and co-signs all AF Forms 469 which include MRs of more than 30 days duration within one duty day of MSME signature within ASIMS (or by COB on the next UTA for the ARC). **(T-2).**

2.9.4. Will perform final review and co-signs all AF Forms 469 completed by the healthcare provider when the FAE duration is greater than 180 days. **(T-1).** The PO will accomplish this review within one duty day of the MSME signature within ASIMS (or by COB on the next UTA for the ARC). **(T-2).**

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

2.9.6. When considering superseding a provider's recommendations, will communicate the reason(s) to the provider, the SGH, and the SPO. In cases where there is disagreement on profiling, duty limitations or FAE, the SPO will make the final determination after review of the records and, when appropriate, consultation with the unit CC. **(T-2).**

2.10. Medical standards management element (MSME).

2.10.1. Must be a 4N0X1F, flight and operational medical technician, or civilian equivalent. **(T-2).**

2.10.2. Manages the profiling/duty limitation system IAW this publication and AFI 48-149.

2.10.2.1. Will review and sign all AF Forms 422. **(T-1).**

2.10.2.2. Will accomplish a quality review of the forms using MTF acceptable and approved practices. **(T-2)**

2.10.2.3. Will track and report compliance with AF Forms 422 and 469 processing timelines to the DAWG. Notifies SGH, SGP or SPO regarding timeline compliance issues as soon as possible after issues are identified. **(T-2)**

2.10.2.4. Will perform administrative quality reviews of DLCs, FAE with durations greater than 180 days, physical examinations for qualification purposes, profiles, and appropriate clearances before these documents are finalized (**Exceptions:** routine PHAs, RILO packages). **(T-1).**

2.10.2.5. Through ASIMS, will ensure distribution of AF Forms 422 and AF Forms 469 as directed in this publication to the Airman's CC (and/or the CC's designees IAW AFI 41-200). **(T-1).** Care will be taken to ensure that distribution of a patient's protected

health information is limited to the minimum necessary and that these disclosures are properly accounted for IAW AFMAN 41-210. **(T-1)**.

2.10.2.6. Will perform administrative quality control review on AF Forms 422 and AF Forms 469 after IRILO, fitness for duty (FFD), MEB or physical evaluation board processing as applicable. **(T-1)**. Will ensure ALC-C restrictions (or their removal) are correctly applied on the AF Forms 469 or AF Forms 422 as directed by AFPC/DP2NP or ARC SGP IAW AFMAN 41-210. **(T-1)**.

2.10.3. Will serve as the liaison between unit commanders, health care providers, POs, and Airmen. **(T-2)**

2.10.4. Will perform required actions for personnel referred by Military Personnel Section (MPS), or applicable agency, for retraining, PCS, Separation/Retirement, or special duty clearance. **(T-2)** Actions include, but are not limited to: Airmen recommended for retraining; applicants for special duty assignments or Palace Chase; PME or other formal school clearances; Airmen identified for overseas PCS clearances; Airmen requiring security clearance; or other physical qualification actions.

2.10.4.1. The MPS will include available AFSCs and job descriptions for Airmen referred for retraining. **(T-1)**

2.10.4.2. Retraining Personnel: MSME will review retraining applications to ensure Airmen are qualified for entry into AFSC(s) specified for potential retraining. **(T-1)** The AF Form 422 will indicate each of the selected AFSCs the Airman is and is not qualified to enter. **(T-1)** See AFI 48-123 for additional information.

2.10.4.3. Will review assignment actions to ensure Airmen are medically qualified for PCS to gaining base IAW applicable personnel processing codes. **(T-1)** The AF Form 422 will contain a statement as indicated by personnel processing codes listing. **(T-1)**

2.10.4.4. Palace Chase/Front Applicants: The MSME will review applicant medical records to ensure RegAF members applying for Palace Chase and Palace Front meet retention standards IAW AFI 48-123 and the Medical Standards Directory. **(T-1)** If disqualifying medical conditions are discovered, the member will be referred to the PCM and/or the AMRO board for further evaluation/review. **(T-1)**

2.10.5. Will screen officers who have been matched to overseas senior command positions through the command screening board for mobility restrictions (and potentially items that do not meet retention standards) as soon as possible after being notified of assignments. **(T-1)**

2.10.5.1. For officers who have been matched through the command screening board, MSME will not wait for deployment/permanent change of station (PCS) orders before initiating clearance. **(T-1)** The colonels management office (A1LO) will instruct matched officers to initiate clearance immediately through their servicing MSME. A1LO will also provide the names to AFMRA who will distribute them through the appropriate MAJCOMs to the members' servicing MSMEs. MSME will inform A1LO of any matched officers with mobility restrictions. **(T-1)**

2.10.5.2. Pre-deployment requirements that must be accomplished closer to the required report date do not need to be included in this initial clearance.

2.10.6. MSME will attend the AMRO board and DAWG, produce metrics and required reports IAW this publication and per SGP direction. (T-1) ARC AMRO board members and public health (PH) representatives are highly encouraged to attend co-located AD AMRO board meetings. Additionally, MSME will:

2.10.6.1. Perform the required reviews as indicated in [paragraph 4.5.2](#) of this publication in preparation for the AMRO board and DAWG. (T-1)

2.10.6.2. Assist the PCM and physical evaluation board liaison officer (PEBLO), via the AMRO board, in identifying other Airmen who require RILO. (T-1)

2.10.6.3. Ensure that AMRO board decisions secondary to trigger events are appropriately documented in ASIMS “Refer to AMRO board” section in ASIMS.

2.10.7. MSME is designated as the MTF ASIMS administrator, and will conduct the following duties associated with this role: (T-2)

2.10.7.1. Regularly update/validate unit contact information to ensure currency/accuracy for ASIMS notifications. (T-1)

2.10.7.2. Coordinate with the MTF HIPAA Privacy officer to ensure that the unit commander designates in writing those members of the unit approved to receive HIPAA-protected information, as well as those members allowed role-based access to ASIMS. (T-1) This information must be updated on a regular basis, at least annually. (T-1)

2.10.8. ARC medical unit MSME: During UTA, MSME will prepare all open AF Forms 422 and AF Forms 469 for signature and finalization by the SGP by COB of the last day of the UTA unless specific circumstances prevent it. (T-2) The MSME must discuss with the SGP those circumstances that prevent closure of the forms. (T-2)

2.11. PH (or ARC Equivalent). Manages pregnancy DLCs IAW [paragraph 3.5](#) of this publication. (T-1)

2.12. Unit commanders.

2.12.1. Will ensure unit and individual medical readiness IAW AFI 10-250.

2.12.2. Will ensure unit Airmen are available for and complete examinations including required follow-up studies and final disposition in a timely manner. (T-2)

2.12.3. Will work with MSME (the ASIMS administrator) to ensure appropriate unit staff are designated to receive notification via ASIMS of information on individual Airmen IAW DoDI 6025.18, *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs*; Department of Defense manual (DoDM) 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs*; and AFI 41-200. Unit commander will ensure contact information is current and accurate and provided to the ASIMS administrator. (T-1).

2.12.4. Will ensure that unit Airmen have access to receive AF Forms 422 and AF Forms 469 via ASIMS. (T-2). Will ensure Airmen receiving an AF Form 422 or AF Form 469 are counseled and/or provided written instructions on duties and responsibilities when appropriate. (T-2).

2.12.4.1. For AF Form 469 actions which do not limit mobility, the commander is not required to sign the form and may delegate these requirements to the unit first sergeant and the Airman's supervisor.

2.12.4.2. For AF Form 469 actions which limit mobility, the commander must sign the AF Form 469 prior to release to the Airman. **(T-2)**.

2.12.4.3. If the commander non-concurs with mobility restriction on an AF Form 469, the commander (or designee if commander is away) will contact the MTF/SGP within seven duty days using ASIMS. **(T-2)**. See [paragraph 3.4.2](#) of this publication for further guidance. ARC only: commanders who are traditional reservists/guardsmen will contact the SGP no later than the end of the next UTA. **(T-2)**.

2.12.5. Maintain awareness of the FFD status of the service members under their command. **(T-1)**.

2.12.6. Contact the SGP or SGH if there are concerns about the reliability of past and/or present DRs or MRs. **(T-2)**.

2.12.7. Ensure unit Airmen understand their roles and responsibilities in this publication. **(T-2)**

2.12.8. Report any trigger events (see [paragraph 4.4.4.3](#) for details) to the SGP, and/or MSME. Will use the "Refer to AMRO board" function within ASIMS for referral, but may use other means for communication in addition to this if desired. **(T-2)**.

2.12.9. For Airmen who belong to a squadron where the commander is dual hatted as the SGP, the SGP duties for the Airman's case will be delegated to either the SGH or next senior FS.

2.13. Airmen.

2.13.1. Will report any new medical condition, or any change in medical status, to the appropriate medical provider at the time of onset. **(T-1)** The Airman must also report all medical/dental treatment obtained through civilian sources to the appropriate military medical authority IAW AFMAN 41-210. **(T-1)** See AFI 48-123 for additional guidance regarding ARC Airmen.

2.13.2. Must attend all scheduled medical appointments as directed and inform unit supervisor of required follow-up evaluations and appointments. **(T-3)**.

2.13.3. Will make all attempts to resolve medical conditions in a timely manner. **(T-1)** This includes, but is not limited to, attendance at all appointments, active participation in rehabilitation, and using medications as prescribed by the health care provider. Failure to meet this requirement, as determined by an appropriate medical authority and the Airman's commander, may result in MEB, FFD, and resultant administrative separation from the AF, without medical disability compensation.

2.13.4. When an Airman's failure to comply with medical assessment requirements renders the Air Force Medical Service (AFMS) unable to determine the Airman's current medical status, the following actions will be deferred: clearance actions for deployment, PCS, retraining, attendance at service academies or PME, military personnel appropriation (MPA) or Reserve Personnel Appropriation (RPA) orders, or any other orders status to include

medical continuation (MEDCON) orders (ARC). **Note:** See AFI 36-2910 for guidance relating to MEDCON orders. **(T-2).**

2.14. Military personnel section (MPS).

2.14.1. Must, upon request, provide a listing of personnel with AAC of 31, 37, or 81 (pregnancy) and deployment availability code deployable with limitations (DW) from military personnel data system to MSME. **(T-2).**

2.14.2. Will refer to MSME any Airman requiring special medical clearance actions and includes the medical requirements member must meet. **(T-1).**

2.15. Air Force Personnel Center, Medical Standards Department (AFPC/DP2NP), Air National Guard/Chief of Aerospace Medicine (ANG/SGP), Air Force Reserve/Chief Medical Operations Division (AFRC/SGO).

2.15.1. AFPC/DP2NP reviews all RegAF RILO (initial and annual) cases.

2.15.2. Respective ANG/SGP or AFRC/SGO reviews ARC cases IAW AFMAN 41-210.

Chapter 3

ESTABLISHING AND DISSEMINATING DUTY LIMITATIONS

3.1. General Requirements.

3.1.1. Completion of an AF Form 469. When a provider determines an Airman has a duty, mobility, or fitness limitation, the provider will use the AF Form 469 to document the limitation(s). **(T-1)**.

3.1.1.1. Providers will document functional limitations on the AF Form 469 to convey necessary detail to allow the CC to make informed decisions concerning the management of his/her personnel. **(T-1)**. Limitations will be timely, accurate and unambiguous and be written in simple terms understandable by non-medical leadership and supervisors. **(T-1)**.

3.1.1.2. Duty restrictions in the AF Form 469 will contain no positive affirmations regarding the Airman's workplace or what the Airman can do in the workplace. **(T-1)** However, the AF Form 469 may contain positive ("should", "can", "will", etc.) instructions regarding an Airman's medical management.

3.1.2. Completion of an AF Form 422.

3.1.2.1. The AF Form 422 will be updated when completing other medically related personnel functions, which include initial qualification, military retraining, PCS (if appropriate), PME, and similar functions as directed in this guidance. **(T-1)**.

3.1.2.2. The AF Form 422 will be updated after a RILO (with or without initiation of an ALC-C), MEB, worldwide duty or FFD evaluation. **(T-1)** In these cases, a PULHES determination will be re-accomplished on an AF Form 422 to reflect updates from the RILO, MEB, worldwide duty, or FFD determination. **(T-1)** If a member has an ALC-C removed during another AFPC/DP2NP, ANG/SGP or AFRC/SGO review, the AF Form 422 will be updated to reflect the new PULHES. **(T-1)**

3.2. Fitness restrictions (FR) and fitness assessment exemptions (FAE). If an Airman has a medical condition affecting fitness, but not impacting mobility, retention, or AFSC duties, the provider who initially assesses the condition will generate an AF Form 469. **(T-1)**. **Note:** These actions will be accomplished by the ARC medical liaison officer (or other appropriate designee) for ARC Airmen IAW AFI 36-2905.

3.2.1. The unit CC may choose to apply the draft FAE if the final AF Form 469 has not been received at the time of FA: however, the final AF Form 469 will supersede the draft recommendations for all future FAs.

3.2.2. Permanent fitness profiles.

3.2.2.1. Permanent fitness profiles will require approval at the AMRO board prior to final signatures.

3.2.2.2. Permanent fitness profiles will require a note from the orthopedist or other appropriate specialist documenting medical condition is permanent, not likely to improve, and recommends avoiding specific fitness activities (e.g., running, pushups, situps).

3.2.2.3. Permanent profiles can only be for fitness.

3.2.2.3.1. Airmen are not eligible for permanent mobility or duty restricting profiles.

3.2.2.3.2. Member must still be able to perform physical actions required for deployment.

3.2.2.4. Permanent profiles may have multiple fitness restrictions without necessarily requiring an IRILO, as long as member can still perform required actions for duty and deployment.

3.2.2.5. Permanent profiles will require annual validation during PHA review (in ASIMS).

3.2.3. If an Airman has a valid AF Form 469 and changes duty location (PCS, etc.), the AF Form 469 is valid at the gaining installation for FRs and FAEs. **(T-2).**

3.2.4. Abdominal circumference exemptions must be reviewed and approved by the AMRO board before final closure by any MTF PO and transmission to the unit. **(T-1). Exception:** AC exemptions for pregnancy do not require AMRO board review.

3.3. Duty Restrictions (DR) Only.

3.3.1. For DRs with no mobility, retention, retraining, or fitness implications, the AF Form 469 signed by the health care provider is made available electronically via ASIMS to MSME for review and signature. Following MSME signature, the information is made available via ASIMS email notification to the Airman's unit. PO review/signature is not required.

3.3.2. DRs that could permanently affect an Airman's ability to perform his/her AFSC-specific duties, but do not affect continued military service or mobility, will be reviewed by the AMRO board. After review, a recommendation will be made to the commander to make a determination on the Airman administratively, beginning with AFSC disqualification IAW AFI 36-2101 and AFI 48-123. **(T-1).**

3.3.2.1. The base operational medicine cell provider (or MSME with provider instruction/oversight) will initiate a new AF Form 422 stating "Member meets AF retention standards for continued service but does not meet AFSC-specific physical standards and is therefore disqualified for AFSC XXXX". **(T-1).** The diagnosis or other medical justification for the statement will not be placed on the AF Form 422. **(T-0)**

3.3.2.2. MSME will review the AF Form 422 with the Airman. **(T-2).** MSME will edit the AF Form 422 to annotate medical qualification statements for any prior AFSCs that have been held by the Airman. **(T-1).** **Note:** If MSME assesses that the Airman may not be eligible for retraining, the case will be referred to the AMRO board for IRILO consideration. **(T-1).**

3.4. Mobility Restrictions (MR).

3.4.1. When a medical condition will prevent an Airman from deploying, with or without duty or fitness limitations, the provider will check the MR box on the AF Form 469 and enter the release date of the restriction. **(T-1).**

3.4.1.1. MR profiles 90 days or less will be considered light duty profile(s), IAW DoDI 1332.45, *Retention Determinations for Non-Deployable Service Members*, and will have

the following statement automatically included in the restrictions section of the AF Form 469: “Airman has a DLC that is expected to resolve in 30 days, extendable up to 90 days. The Airman will have his/her medical situation reviewed at least monthly at the AMRO board to ensure progression of plan of care.” Profiles that start off as 90 days or less, but get extended to 91-365 days, will no longer be considered light duty profiles.

3.4.1.2. When the medical condition would prevent the Airman from deploying to some, but not all forward locations, the provider will check the “DW Deployable With Limitations” box on the AF Form 469 and enter the release date of the restriction. The provider must clearly document what the Airman’s limitations are so the CC can make an accurate decision as to whether or not the Airman can deploy to a needed location.

3.4.2. If a CC chooses to non-concur on the MR, the CC must use the ASIMS system to contact the MTF/SGP within seven duty days (COB on last day of UTA for ARC) of receipt of the mobility restricting AF Form 469 (no contact from the CC will be considered concurrence). **(T-2)**. The MTF must re-adjudicate and resubmit the profile to the commander within an additional seven duty days. **(T-2)**.

3.4.2.1. If the MTF/SGP and Unit CC still disagree after the re-adjudication, the profile will stand, as it is a medical recommendation, and the commander can choose to accept the recommendation or not. Rationale for the medical decision will be documented by the MTF/SGP in the Airman’s medical record. **(T-2)**.

3.4.2.2. A specified deployment may have medical requirements determined by the COCOM. Thus, while a CC may place an individual on mobility regardless of medical recommendations, the gaining COCOM may not accept the Airman for deployment. For a defined deployment, the MTF will coordinate through its MAJCOM to the gaining COCOM regarding waiver of defined medical requirements. **(T-1)**.

3.4.2.3. In the event of a CC’s non-concurrence on an AF Form 469 for an Airman with a condition which is unfitting for continued military service, an IRILO will still be prepared and forwarded to AFPC/DP2NP, ANG/SGP or AFRC/SGO. **(T-1)**.

3.4.3. Permanent MRs (e.g., ALC-C) may only be determined by AFPC/DP2NP, ANG/SGP or AFRC/SGO. These mobility limitations will be displayed on the AF Form 469 or AF Form 422 permanently at the bottom of the physical limitations/restrictions portion. Once assigned, permanent MRs will not be changed, removed, or overridden by any local DLC or profile action (additional restrictions may be added as appropriate). **(T-1)**. Only waiver authorities as described in AFMAN 41-210 may authorize deployment for individuals placed on ALC restrictions. Unit CCs may not non-concur with MRs directed by AFPC/DP2NP, ANG/SGP or AFRC/SGO (e.g., ALCs).

3.5. Pregnancy-Related Duty and Fitness Limitations.

3.5.1. When an Airman is diagnosed as pregnant, PH will be notified via direct referral from the provider or clinic staff, by an AF Form 469 initiated by the provider, or through other appropriate, locally developed means, IAW AFI 44-102, *Medical Care Management*. For ARC, the Airman is required to notify the medical unit and provide proof of pregnancy. Upon receipt of a new AF Form 469 for pregnancy, MSME will immediately forward it to PH, as the action office for the Fetal Protection Program, for appropriate action.

3.5.1.1. PH, in coordination with the PCM and, if applicable, the woman's health provider, will issue an initial AF Form 469 within 5 duty days of notification to PH or MSME of a positive pregnancy test. **(T-1)**. The AF Form 469 will include standard DRs, MRs, and FRs (IAW [paragraph 3.5.2](#) of this publication). **(T-1)**. For the ARC, the AF Form 469 will be processed the next UTA. **(T-1)**.

3.5.1.2. For pregnant Airmen assigned to a workplace monitored as part of the Occupational and Environmental Health Program (OEHP), standard duty limitations may require additional or altered limitations, based on workplace-specific hazards IAW AFMAN 48-146, *Occupational & Environmental Health Program Management*. If indicated by the OEHP, the Airman's worksite will be evaluated for hazards that could affect the mother or fetus. **(T-1)**. If this evaluation indicates the need for a change in the standard duty limitations, the AF Form 469 will be modified within 15 duty days (within two UTAs for ARC) of initial PH notification with restrictions tailored to the hazards of the Airman's workplace. **(T-1)**. Bioenvironmental engineering will provide a written workplace evaluation to PH based on either the latest workplace survey (if conducted within the last 12 months) or a specific site visit to identify workplace hazards. **(T-1)**. PH will, in turn, coordinate with the installation occupational and environmental health consultant and the woman's health provider or PCM to finalize the duty limitations on the AF Form 469. **(T-1)**. ARC may have civilian obstetrics and gynecology (OB/GYN) consultation on duty limitations.

3.5.1.3. Duty limitations associated with pregnancy may require temporary removal from certain AFSC duties. Retraining will not be required.

3.5.2. The OB/GYN Consultants to the AF/SG will validate the AF standard DRs, MRs, and FRs for pregnancy annually and produce an updated AF Form 469 pregnancy template. The DAWG may approve changes to the standard template when deemed appropriate at a local level. Changes will be documented in the DAWG minutes. **(T- 1)** The primary care team need take no further action for the code 81 on the AF Form 469 upon completion of pregnancy, if the pregnancy ended at approximately the originally-estimated time of delivery. The primary care team will manually change the code 81 to reflect the end date of pregnancies ending earlier than 37 weeks gestation (by a process developed at the MTF level). **(T- 1)**

3.5.3. Fitness restrictions exempting Airmen from completing a fitness assessment following a pregnancy will be documented in an AF Form 469. The duration of the exemption will be dependent on the duration of the pregnancy, as outlined below.

3.5.3.1. A pregnancy duration of at least 20 weeks will have a fitness assessment exemption of 365 days.

3.5.3.2. A pregnancy duration of 12-20 weeks will have a fitness assessment exemption of 180 days.

3.5.3.3. A pregnancy duration up to 12 weeks will have a fitness assessment exemption of up to 60 days.

3.5.3.4. Any medical conditions complicating the pregnancy may warrant adjustment of the FAE. Providers will use clinical judgement for these situations as indicated.

3.6. Multiple Action AF Form 469. If an Airman requires an AF Form 469 with multiple purposes (mobility, duty, and/or fitness), a diagnosis associated with an ALC after being returned to duty following an IRILO will be the primary diagnosis. Other mobility restricting diagnoses will have the next highest priority for processing. **(T-1).**

3.7. External Duty Limitations (Civilian or Sister Service). All AF personnel must report changes in physical status to their AF military medical unit. **(T-1)** Duty limitations from a non-AF provider are regarded as a recommendation only and must be entered on an AF Form 469 to be valid. **(T-1)** AF providers retain final duty, fitness, and mobility recommendation authority. **(T-1).**

3.8. Dental.

3.8.1. When an Airmen is placed into dental readiness classification 3, an AF Form 469 will be initiated. **(T-1).** The AF Form 469 will be the primary means of notifying CCs that a member is in dental readiness classification 3. **(T-1).** See AFMAN 47-101, *Managing Air Force Dental Services*, for more information.

3.8.2. Dental readiness classification 4 generally does not require an AF Form 469, however, if the class 4 extends beyond 30 days without resolution, an AF Form 469 may be used, at the discretion of the Chief of Dental Services in consultation with the SGP, as an additional tool to communicate the non-deployable status of the Airman to the unit. Air Force Reserve Airmen in dental readiness classification 4 may be restricted from participation IAW AFMAN 36-2136, *Reserve Personnel Participation*.

Chapter 4

AIRMEN MEDICAL READINESS OPTIMIZATION (AMRO).

4.1. Purpose. AMRO is the AFMS paradigm to optimally manage Airmen with MR due to medical and/or mental health condition(s). Activities include timely scheduling of specialty consultations, appropriate follow-up with the warfighter care team (WCT), troubleshooting barriers to care, and monitoring Airmen adherence to treatment plans. In addition, AMRO promotes collaborating with commanders, both for awareness of deployable unit forces, and to create mutual dialogue to accelerate Airmen returning to duties or referral into the Disability Evaluation System (DES) process. (For ARC, the underlying principles will be followed, but the ARC will not be required to follow items outlined in critical success factors 1 and 2, as they do not apply.) AMRO is comprised of three critical success factors:

4.2. Critical success factor 1: Team AMRO Time.

4.2.1. Team AMRO Time is protected time - 3 hours per week minimum - outside of the exam room that will be allocated for the entire WCT by the MTF CC to meet and discuss MR Airmen. **(T-1)**. Additional time above the 3 hour minimum may be allotted at the discretion of the MTF CC (with accompanying appointment decrement approved by DHA via the standard process).

4.2.2. Team AMRO Time will occur at a standing time weekly, and is in addition to time spent participating at the AMRO board. **(T-1)**.

4.2.3. All protected time will comply with DHA-approved appointment decrements in operational medical readiness squadron and AD only empaneled clinics. **(T-1)**.

4.3. Critical success factor 2: Standard Work. AMRO standard work requires all WCT members present for duty reviewing all MR Airmen on their team ([Attachment 3](#)). WCT members will:

4.3.1. Prioritize review of Airmen with new profiles and/or open referrals. **(T-1)**.

4.3.2. Review barriers to care. **(T-1)**.

4.3.2.1. Review the timeliness of referrals with the AMRO board, as necessary. **(T-1)**.

4.3.2.2. Determine which Airmen may benefit from nurse case manager expertise, and coordinate with the Case Manager on needed care. **(T-1)**.

4.3.3. Review Airmen adherence to agreed treatment plan and reasons for deviating from the plan. **(T-1)**.

4.3.4. Determine when and how MR Airmen require WCT follow up. **(T-1)**.

4.3.5. Communicate with MR Airmen at least monthly to validate status of care, plan for improvement, and discuss barriers to care. All contacts with Airmen must be documented in the electronic health record and coded appropriately. **(T-1)**.

4.3.6. Communicate with specialty providers as needed. **(T-1)**.

4.3.7. Update medical care plans and AF Forms 469. **(T-1)**.

4.3.8. Remove MRs as directed by AMRO board. **(T-1)**.

4.3.9. Communicate with CCs. (T-1).

4.4. Critical success factor 3: AMRO board.

4.4.1. The AMRO board will be established at each wing/base level and will meet to review personnel with a DLC that affects mobility, retention, or long-term physical fitness. The board will validate the WCT's plan of action for each case, identifying and removing obstacles to care, so that the Airman is restored to health/mobility status, or set up to enter the DES process in the least amount of time possible. (T-1).

4.4.1.1. The AMRO board is authorized to direct placement of a code 37 and IRILO NARSUM to initiate referral to AFPC/DP2NP for retention determination.

4.4.1.2. The AMRO board is authorized to direct removal of a code 37. It is appropriate only for rare circumstances where the Airman's medical condition has significantly improved such that the Airman no longer is disqualified for medical retention standards, and the IRILO NARSUM has not been forwarded to AFPC/DP2NP for disposition.

4.4.2. The AMRO board will consist of (T-1):

4.4.2.1. SGP – Chairman.

4.4.2.2. SGH – Alternate chairman. Can be made chairman if deemed appropriate per MTF/CC and MAJCOM/SGP via waiver.

4.4.2.3. Chief nurse.

4.4.2.4. PEBLO.

4.4.2.5. Medical standards management element (MSME).

4.4.2.6. TRICARE operations and patient administration representative (preferably referral management, when possible).

4.4.2.7. Case management representative.

4.4.2.8. Utilization management representative.

4.4.2.9. Warfighter care team: provider, nurse, and technician (May be MH providers and technicians).

4.4.2.10. Others as needed, based on local availability and case pathology (e.g., physical therapy, dietitian, MH, exercise physiologist, etc.). CCs and/or first sergeants can be invited to be part of an AMRO board to talk about their members (only) if indicated.

4.4.3. AMRO board meeting frequency and time commitment.

4.4.3.1. Frequency of AMRO board meetings depends on the number of WCTs caring for RegAF Airmen.

4.4.3.2. Each WCT will meet with AMRO board every other week. (T-1).

4.4.3.3. MTFs should estimate at least 1 hour of time per AMRO board for 3 WCTs, time dependent on the number and severity of Airmen on MRs.

4.4.3.4. The AMRO board at ARC installations should meet monthly, but must meet not less than quarterly. (T-2). At co-located bases, ARC representatives are highly encouraged to participate in the RegAF host base AMRO board to ensure ARC Airmen

requiring IRILOs and/or MEBs are managed appropriately (e.g. through RegAF channels for duty related conditions or through ARC for NDR-DES).

4.4.4. Potentially unfitting cases will be reported to the AMRO board based on five trigger events. **(T-1)**. A trigger event is a condition or occurrence which may indicate a service member has (a) medical and/or MH condition(s) that is (are) inconsistent with retention standards or deployability. Trigger events include, but are not limited to, the following:

4.4.4.1. Provider discovers a potential or questionable service-disqualifying medical condition for an Airman. The provider is responsible for submitting the case to the AMRO board. If the provider is uncertain whether the case requires IRILO, it will still be referred for AMRO board review.

4.4.4.2. AMRO surveillance that determines a member has a chronic condition that doesn't meet retention standards because of one of the following reasons. Note: regardless of the diagnosis, after 12 months of cumulative AAC 31 status for the same or related issue(s), the full case must be referred to AFPC/DP2NP, ANG/SGP or AFRC/SGO via an IRILO for adjudication review. **(T-1)**.

4.4.4.2.1. The member's condition may preclude him/her from performing AFSC duties

4.4.4.2.2. The member's condition may prevent him/her from deploying to field conditions

4.4.4.2.3. The member may have an unfitting condition and/or will not return to mobility status prior to 365 cumulative days for the condition or related issue(s).

4.4.4.2.4. DAWG surveillance. Reference [4.5.2](#) for more details.

4.4.4.3. Commander requests evaluation (via "Refer to AMRO board" function in ASIMS) of unit service members due to poor duty performance or deployment concerns stemming from a potential medical or mental health condition.

4.4.4.4. AFPC/DP2NP, ANG/SGP or AFRC/SGO directed. AFPC/DP2NP may identify conditions via an annual or modified RILO and direct the MTF to submit an IRILO package.

4.4.4.5. PCS, temporary duty or deployment cancellation or curtailment for a medical or MH reason.

4.4.5. All trigger events from the base level (i.e. provider, commander, MSME/base operational medicine cell reviews) will be reported to the AMRO board via the "Refer to AMRO board" function in ASIMS. **(T-1)**.

4.4.6. Other AMRO board Functions:

4.4.6.1. Review of any other "Refer to AMRO board" cases.

4.4.6.1.1. For cases referred to the AMRO board, the AMRO board will determine whether an Airman's condition(s) meets standards for continuing military service IAW AFI 48-123. **(T-1)**. The disposition of the AMRO board review will be documented within the ASIMS "refer to AMRO board" tool and may include:

4.4.6.1.1.1. Case dismissal.

4.4.6.1.1.2. IRILO or NDR-DES referral.

4.4.6.1.1.3. Defer decision for certain period of time, maximum 90 days.

4.4.6.1.2. Once a case is referred to the AMRO board, it should be reviewed at the next scheduled AMRO board meeting, but must be reviewed no more than 45 days after the referral is made (for ARC 90 days). **(T-1)**.

4.4.6.2. AAC, pregnancy reviews.

4.4.6.3. Modified RILO due dates.

4.4.6.4. MEDCON cases.

4.4.6.5. Validation of Deployment With Limitations (DW) deployment availability codes.

4.5. Metrics.

4.5.1. The DAWG will produce and provide a metrics report to the MTF executive committee via the aerospace medicine council (AMC). **(T-1)** The MSME function will develop the report from ASIMS data reflecting the current status of the wing and supported units, reporting through the DAWG to the MTF executive function and wing commander (as required) via the AMC. **(T-1)** Components of the report will include:

4.5.1.1. Fully medically ready capable percentage. These Airmen fulfill all ASIMS requirements and are capable of deploying with no medical actions required.

4.5.1.2. Partially medically ready percentage. These Airmen do not have an AAC 31, 37, or 81. They do have unmet ASIMS requirements that could be resolved within 30 days.

4.5.1.3. Not medically ready percentage. These Airmen would require more than 30 days to become fully medically ready and include those with AAC 31, 37, or 81. It also includes Airmen with any ALC. Airmen on a Code 31 for 31-90 days, considered on a light duty profile, will still be considered not medically ready for the purposes of reporting metrics at the DAWG, even though they are considered deployable by AFPC.

4.5.2. Diagnosis and Medication Surveillance. At least ten times per year, MSME will present findings to the DAWG of selected diagnostic or medication usage queries (without using any names of Airmen) as directed by the SGP. **(T-1)**. This ensures Airmen with certain medical conditions do not remain unidentified in the mobility reporting system. MSME will ensure the reviews of specific Airmen are performed (outside of the AMRO board or DAWG). For members that are found to potentially need DLC action or IRILO, a "Refer to AMRO board" will be made in ASIMS, and the case will be discussed at the AMRO board. Results of the findings will be presented at the DAWG. **(T-1)**. The SGH will ensure these findings are also presented at the professional staff or other appropriate forum at least annually. **(T-2)**. ARC will perform no less than quarterly. **(T-1)**.

4.5.3. In addition to the above metrics, the DAWG will track the following data each month and report to the MTF executive committee via the AMC (quarterly for the ARC): **(T-1)**.

4.5.3.1. Timelines and outcomes related to IRILOs/MEBs, as follows:

- 4.5.3.1.1. Average duration from the date a potential IRILO case via a trigger event is identified to the PEBLO/MSME until the AMRO board disposition. **(T-2)**. Metric standard is less than 45 days. Each specific case that exceeds the metric will be documented in the AMRO board minutes including the cause for the delay. **(T-2)**.
- 4.5.3.1.2. Average duration from AMRO board determination for IRILO until the case is transmitted to AFPC/DP2NP, ANG/SGP or AFRC/SGO as applicable (cases dismissed by the AMRO board will not be included). **(T-2)**. Metric standard is less than 30 days. Each specific case that exceeds metric will be documented in the AMRO board minutes. **(T-2)**.
- 4.5.3.1.3. Average duration from AFPC/DP2NP, ANG/SGP or AFRC/SGO notification to the MTF to conduct an MEB until referral into DES. **(T-2)**. Metric within 10 duty days (ARC next UTA). Each case that exceeds metric will be documented in the AMRO board minutes. **(T-2)**.
- 4.5.3.1.4. DES metrics as stated by AFMAN 41-210 and other guidance to PEBLO to monitor the DES process. Each case that exceeds metric will be documented in the AMRO board minutes. **(T-2)**.
- 4.5.3.2. Overdue rate for annual RILO cases (# cases overdue at time of DAWG meeting/total ALC-C cases in MTF rosters).
- 4.5.3.3. Results of clinical quality review and recommended actions for significant trends identified.
- 4.5.4. This list of metrics for the DAWG report is not exclusive of other metrics deemed appropriate by the DAWG or higher authority.
- 4.5.5. DLC quality review. The SGP and/or SGH will direct or conduct a review of the quality of DLC determinations and FAE as documented on AF Form 469 and present monthly statistics (quarterly for the ARC) to the DAWG on this review. **(T-1)**.
- 4.5.5.1. The results will be presented to the professional staff (or ARC equivalent) at least annually or more frequently as determined by the DAWG. **(T-2)**.
- 4.5.5.2. The number of DLCs to be reviewed will be determined by the DAWG (and documented in the minutes at least annually) but shall be an adequate sample to provide an accurate representation of the quality of DLCs in the MTF. **(T-2)**.

Chapter 5

LIMITED SCOPE MILITARY TREATMENT FACILITIES (LSMTFS) AND MEDICAL AID STATIONS (MASS)

5.1. Definitions.

5.1.1. LSMTFs are medical elements, flights, or small medical squadrons with a credentialed medical provider that do not provide the scope of services found in a MDG. LSMTFs are typically assigned to a line squadron or group (e.g., air base squadron, mission support group or air base group). In some cases, a LSMTF may report directly to a wing or MAJCOM.

5.1.2. MASs are small medical elements without a credentialed medical provider and are typically located at a geographically separated unit (GSU) or a munitions support squadron (MUNSS) site.

5.1.3. GSUs are units that are not at the same physical location or base as the parent unit.

5.1.4. MUNSS sites are GSUs responsible for receipt, storage, maintenance and control of United States war reserve munitions in support of the North Atlantic Treaty Organization and its strike missions. See AFMAN 21-200, *Munitions and Missile Maintenance Management*.

5.2. Responsibilities.

5.2.1. MAJCOM/SG. The MAJCOM/SG for the supported GSU and MUNSS (LSMTF, MAS, and GSU without LSMTF or MAS) will assign the nearest AD AF MTF as the supporting MTF (with written concurrence of the MAJCOM/SG for the supporting MTF if assigned to a different MAJCOM), for each GSU and MUNSS within their area of responsibility to assist with the documentation and administrative management of Airmen with DLCs.

5.2.2. Supporting MTF/CC.

5.2.2.1. Is ultimately responsible for the documentation and administrative management of Airmen with DLCs as defined in this AFI at the GSU and MUNSS sites and will ensure appropriate support is provided. **(T-1)**.

5.2.2.2. Will administer the program objective memorandum for additional MTF personnel to meet the requirements to support assigned GSU and MUNSS sites based on current manpower models and increased workload. **(T-1)**.

5.2.2.3. Will ensure a credentialed provider, preferably a profile officer (PO), is available to counsel Airmen placed on AAC 31, 37, or 81 at the GSU and MUNSS sites. **(T-2)**. This counseling may occur via video teleconference or telephone when circumstances do not allow face-to-face contact but will be documented by the credentialed provider in the Airman's electronic medical record. **(T-1)**.

5.2.3. MTF SGP at supporting MTF. Will ensure appropriate documentation and administrative management of Airmen with DLCs at the GSU or MUNSS sites. **(T-1)**.

5.2.4. PO at the supporting MTF will perform PO duties for Airmen assigned to supported GSU or MUNSS sites who require an AF Form 422 or AF Form 469. **(T-1)**.

5.2.4.1. If the GSU or MUNSS site Airman is not empaneled to a PCM at the supporting MTF and receives duty limitation recommendations from a civilian provider, the PO at the supporting MTF will initiate an AF Form 469 using the civilian provider's recommendations as a guide. **(T-1)**. If the GSU or MUNSS Airman is empaneled, the PCM will perform this function. **(T-1)**.

5.2.4.2. The AF provider that transcribes the civilian provider's recommendations retains final authority on the restrictions placed on the AF Form 469. **(T-1)**.

5.2.5. AMRO board/DAWG at the supporting MTF will administratively manage the DLC, AAC 31, 37, 81, ALC-C, and RILO (initial and annual) cases from the GSU and MUNSS sites as outlined in this publication. **(T-1)**.

5.2.6. MSME at the supporting MTF will perform the MSME functions as outlined in this publication for the supported GSU and MUNSS sites. **(T-1)**.

5.2.7. The PEBLO at the supporting MTF will perform his/her functions as outlined in this publication for the supported GSU and MUNSS sites. **(T-1)**. Video teleconferencing, teleconferencing, or electronic data and communication systems may be used to facilitate these functions.

5.2.8. LSMTF credentialed providers will see and treat patients from GSUs and MUNSS sites in the same manner as patients empaneled to them, with regards to care rendered, profiling, and coordination of initial and annual RILOs.

5.2.8.1. If no LSMTF credentialed provider is available, the LSMTF officer in charge/noncommissioned officer in charge will ensure Airmen with a DLC that restricts mobility (AAC 31, 37, or 81) are referred to the supporting MTF to receive counseling by a credentialed provider, preferably a PO. **(T-1)**.

5.2.8.2. This counseling may occur via video teleconference or telephone when circumstances do not allow face-to-face contact but will be documented by the credentialed provider in the Airman's electronic medical record. **(T-1)**.

5.2.9. Officer in charge overseeing MAS:

5.2.9.1. Will ensure that patients presenting for care are evaluated, treated and/or referred as appropriate under the supervision of a credentialed provider. **(T-1)**. **Note:** MAS medical personnel will provide documentation and management of Airmen with DLCs as defined in this publication within their scope of training, manpower, and equipment. **(T-1)**.

5.2.9.2. Will ensure that information for patients with a DLC are entered into ASIMS and, when indicated, made available electronically to the supporting MTF for MSME review and PO approval. **(T-1)**. If ASIMS is not available at the supported site, then will ensure DLC information is forwarded to the supporting MTF for entry into ASIMS. **(T-1)**. MSME will serve as the point of contact for this purpose. **(T-1)**.

5.2.9.3. Will ensure that medical records and medical element staff are made available for the supporting MTF AMRO board. **(T-1)**.

5.2.9.4. Will coordinate with GSU or MUNSS site CCs to ensure Airmen obtain the required exams and studies. **(T-1)**.

5.2.9.5. Will ensure Airmen with a DLC that restricts mobility (AAC 31, 37, or 81) are referred to the supporting MTF to receive counseling by a credentialed provider, preferably a PO. **(T-1)**. This counseling may occur via video teleconference or telephone when circumstances do not allow face-to-face contact but will be documented by the credentialed provider in the Airman's electronic medical record. **(T-1)**.

DOROTHY A. HOGG
Lieutenant General, USAF, NC
Surgeon General

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

DoDI 1332.45, *Retention Determinations for Non-Deployable Service Members*, 30 July 2018

DoDI 6025.18, *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs*, 13 March 2019

DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, 17 August 2011

DoDM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs*, 13 March 2019

AFPD 10-2, *Readiness*, 6 November 2012

AFPD 44-1, *Medical Operations*, 9 June 2016

AFI 10-250 *Individual Medical Readiness*, 16 April 2014

AFI 33-360, *Publications and Forms Management*, 1 December 2015

AFI 36-2101 *Classifying Military Personnel (Officer and Enlisted)*, 25 June 2013

AFI 36-2110, *Total Force Assignments*, 5 October 2018

AFI 36-2905 *Fitness Program*, 21 October 2013

AFI 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay*, 8 October 2015

AFI 36-3206 *Administrative Discharge Procedures for Commissioned Officers*, 9 June 2004

AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members*, 14 April 2005

AFI 41-200, *Health Insurance Portability and Accountability Act (HIPAA)*, 25 July 2017

AFI 44-102, *Medical Care Management*, 17 March 2015

AFI 44-170 *Preventive Health Assessment*, 30 January 2014

AFI 44-176 *Access to Care Continuum*, 8 September 2017

AFI 48-101, *Aerospace Medicine Enterprise*, 8 December 2014

AFI 48-123 *Medical Examinations and Standards*, 5 November 2013

AFI 48-149, *Flight and Operational Medicine Program (FOMP)*, 12 November 2014

AFMAN 21-200, *Munitions and Missile Maintenance Management*, 9 August 2018

AFMAN 36-2136, *Reserve Personnel Participation*, 6 September 2019

AFMAN 41-210, *TRICARE Operations and Patient Administration*, 10 September 2019

AFMAN 47-101, *Managing Dental Services*, 25 July 2018

AFMAN 48-146, *Occupational & Environmental Health Program Management*, 15 October 2018

Guides to the Evaluation of Permanent Impairment, 6th Edition, July 2009, American Medical Association, 1579478889, section. 1.3.

Prescribed Forms

AF Form 422, *Notification of Air Force Member's Qualification Status*. Only computer generated via ASIMS.

AF Form 469, *Duty Limiting Condition Report*. Only computer generated via ASIMS.

AFPC/DP2NP FL4, *Computer Generated Official Air Force Document*. Only computer generated.

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*,

Abbreviations and Acronyms

AAC—Assignment Availability Code

AD—Active Duty

AF—Air Force

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFMS—Air Force Medical Service

AFMRA—Air Force Medical Readiness Agency

AFPC—Air Force Personnel Center

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AFSC—Air Force Specialty Code

AF/SG—Air Force Surgeon General

ALC—Assignment Limitation Code

ALC-C—Assignment Limitation Code-C

AMC—Aerospace Medicine Council

AMRO—Airmen Medical Readiness Optimization

ANG—Air National Guard

ARC—Air Reserve Component

ASIMS—Aeromedical Services Information Management System

CC—Commander

COB—Close of Business
COCOM—Combatant Command
DAWG—Deployment Availability Working Group
DES—Disability Evaluation System
DHA—Defense Health Agency
DLC—Duty Limiting Condition
DoD—Department of Defense
DoDI—Department of Defense Instruction
DR—Duty Restriction
DW—Deployable With Limitations
E—Publishing—Air Force document publishing website (www.e-publishing.af.mil)
FA—Fitness Assessment
FAE—Fitness Assessment Exemption
FFD—Fitness for duty
FL4—Form 4
FR—Fitness Restriction
FS—Flight Surgeon
GMU—Guard Medical Unit
GSU—Geographically Separated Unit
HIPAA—Health Insurance Portability and Accountability Act
IAW—In accordance with
IRILO—Initial Review In Lieu Of
LOD—Line of Duty
LSMTF—Limited Scope Military Treatment Facility
MAJCOM—Major Command
MAS—Medical Aid Station
MDG—Medical Group
MEB—Medical Evaluation Board
MEDCON—Medical Continuation
MH—Mental Health
MPA—Military Personnel Appropriation
MPS—Military Personnel Section

MR—Mobility Restriction
MSME—Medical Standards Management Element
MTF—Military Treatment Facility
MUNSS—Munitions Support Squadron
NARSUM—Narrative Summary
NDR-DES—Non Duty-Related Disability Evaluation System
NILOD—Not in Line of Duty
OEHP—Occupational and Environmental Health Program
OPR—Office of Primary Responsibility
PCM—primary care manager
PCS—Permanent Change of Station
PEBLO—Physical Evaluation Board Liaison Officer
PH—Public Health
PHA—Preventive Health Assessment
PME—Professional Military Education
PO—Profile Officer
PULHES—Physical Profile Serial Chart
RegAF—Regular Air Force
RILO—Review In Lieu Of
RMU—Reserve Medical Unit
RPA—Reserve Personnel Appropriation
SG—Surgeon General
SGH—Chief of the Medical Staff
SGO—Chief, Medical Operations Division
SGP—Chief, Aerospace Medicine
SPO—Senior Profile Officer
TRICARE—The Triple Option Benefit Plan
USAF—United States Air Force
UTA—Unit Training Assembly
VA—Veterans Affairs
WCT—warfighter care team

Terms

Airmen Medical Readiness Optimization (AMRO) board—A multidisciplinary collection of health professionals assembled to manage and facilitate providing optimal health care for AD personnel with mobility limiting restrictions.

ARC SGP—Chief of Aerospace Medicine for the appropriate Air Reserve Component, either Air Force Reserve or Air National Guard. When specific concerns are different for the two reserve components, the components will be specified by name (e.g., ANG/SGP and AFRC/SGO).

Code 31—An AAC used to describe a MR condition which is expected to restrict deployment eligibility for at least 30 days but less than 365 days. AFI 36-2110, *Total Force Assignments*, discusses AACs further.

Code 37—An AAC used to describe a MR condition when the Airman does not meet USAF retention standards and will therefore need a disability evaluation via medical evaluation board (MEB) and/or RILO medical evaluation board. This code also impacts PCS, temporary duty, leave outside the local area, separation, and retirement. AFI 36-2110, discusses AACs further.

Code 81—An AAC used to describe pregnancy as a MR condition. This code also impacts PCS, separation, and retirement. AFI 36-2110, discusses AACs further.

Disqualifying Defect—A medical condition that is unfitting for service in the Air Force IAW AFI 48-123.

Duty Limitation—A recommendation resulting from a medical evaluation which limits or restricts an Airman's ability to perform primary and/or additionally assigned duties, deploy (mobility), or participate in fitness activities.

Duty Limiting Condition—An impairment which prevents an Airman from performing at least some requirements of military service and/or duties expected to be a part of his/her Air Force Specialty Code (AFSC) and/or current assignment. DLCs may also affect additional duties, military details, volunteer service, recreational activity, and/or activities of daily living.

Duty Restriction—A medically prescribed limitation of a person with respect to specified activities. Active duty DRs are prescribed on an AF Form 469. Because DRs are based on a medical condition which is presumed to be an abiding feature of the Airman's health, they apply to Airmen while on duty and while off duty.

Fitness Assessment Exemption—A recommendation resulting from a medical evaluation which restricts one or more components of the Air Force fitness Assessment.

Fitness for Duty—Refers to the evaluation process when a service member has a condition which is questionable or disqualifying for military duty. The process is initiated to evaluate a member's condition that resulted from activities not in the LOD.

Fitness Restriction—A recommendation resulting from a medical evaluation which restricts activities that an Airman may perform as part of a personal, unit-based FP, and/or Air Force fitness assessment.

Functional (or Physical) Limitation—The inability of an Airman to perform specific physical movements or actions based on an assessment of the Airman's injury or illness by a medical professional.

Functional (or Physical) Restriction—A report of an Airman's injury or illness, based on evaluation by a medical professional, that describes specific physical activities or functions that are recommended for the Airman to avoid to allow recovery or reduce risk of further injury.

Impairment—According to the sixth edition of *Guides to the Evaluation of Permanent Impairment*, published by the American Medical Association, impairment is defined as "a significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder or disease."

Medical Evaluation Board (MEB)—The term MEB has several uses. MEB refers to the local assembly of three physicians who review the collection of documents used for processing the member through the DES (NARSUM, CC letter, veteran's administration documents, etc.) for medical sufficiency and maximal medical improvement; this is often referred to as the local MEB. MEB may also informally refer to the entire process where an Airman is evaluated to see if he/she meet retention standards to remain in the USAF, and the subsequent processing of the documents used in this process.

Mobility Restriction—A recommendation resulting from a medical evaluation which limits or restricts an Airman's participation in deployment or mobility actions. Mobility qualifications are outlined in AFI 48-123.

Physical Profile—A long-standing or permanent assessment of an Airman's ability to participate in military activities. The physical profile is described using the PULHES system IAW AFI 48-123 with additional information in the medical standards directory. It is validated annually at the PHA and as needed for actions related to Air Force career development.

Preventive Health Assessment (PHA)—A recurring assessment of an Airman's health status IAW AFI 44-170.

Review In Lieu Of Medical Evaluation Board (RILO)—Package of documents submitted to AFPC/DP2NP to make a retention determination on an Airman, and either return member to duty (with or without limitations), or refer the Airman to the DES. RILOs can be an IRILO or annual RILO determination.

Trigger Event—A condition or occurrence which may indicate a service member has (a) medical and/or MH condition(s) that is (are) inconsistent with retention standards or deployability.

Warfighter Care Team (WCT)—The warfighter care team (WCT) consists of the MTF privileged provider, along with assigned nurse(s)/technician(s), who are primarily involved in managing the medical/mobility restricting issue(s) for the Airman. The WCT will most often be the primary care provider and team, but many times will be a MH provider and team, and sometimes a specialist at a military medical center who is directing care for the MR medical issue. (one air force medical home team is composed of multiple WCTs.) MH or a specialist provider should be considered the lead WCT for a patient when that patient has no condition driving MR other than those conditions for which the Airman is seeing a mental health/specialty provider.

Attachment 2

PULHES SERIAL PROFILE CHART AND ACCEPTABLE AUDIOMETRIC HEARING LEVELS

Table A2.1. PULHES Serial Profile Chart.

	P: Physical Condition	U: Upper Extremities	L: Lower Extremities	H: Hearing (Ears)	E: Vision (Eyes)	S: Psychiatric Stability
1	Free of any identified organic defect or systemic disease.	Bones, joints, and muscles normal. Able to do hand-to-hand fighting.	Bones, muscles, and joints normal. Capable of performing long marches, continuous standing, running, climbing, and digging without limitation.	See Table 2	Minimum vision of 20/200 correctable to 20/20 in each eye.	Diagnosis or treatment results in no impairment or potential impairment of duty function, risk to the mission or ability to maintain security clearance.
2	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.	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.	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.	See Table 2	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.	Worldwide qualified and diagnosis or treatment result in low risk of impairment or potential impairment that necessitates command consideration of changing or limiting duties.
3	Significant defect(s) or disease(s) under good control. 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.	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.	See Table 2	Vision that is worse than E-2 profile (above).	Worldwide 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.
4	Organic defect, systemic or infectious disease which requires, or is currently undergoing, an MEB or IRILO as determined by the AMRO board	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 IRILO as determined by the AMRO board	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 IRILO as determined by the AMRO board.	See Table 2	Visual defects that requires, or is currently undergoing, an MEB or IRILO as determined by the AMRO board.	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 IRILO as

						determined by the AMRO board.
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Table A2.2. Acceptable audiometric hearing level for Air Force.

Table A2.2: 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	AF enlistment, commission, AF Academy, Class I and IA, initial flying class II, RPA Pilot, initial flying class III, ground based controller, missile operator duty, special warfare airmen, survival, evasion, resistance and escape, and selected career fields as noted in the officer and enlisted classification directories.
H-2	35	35	35	45	55	—	Continued service for all flyers, special operator duty; require evaluation for continued flying/special operator duty (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 processing, or review by the DAWG, IAW AFI 48-133 and AFMAN 41-210 for IRILO.

Attachment 3**TEAM AIRMEN MEDICAL READINESS OPTIMIZATION (AMRO) TIME
CHECKLIST****A3.1. Plan for team AMRO time**

A3.1.1. Confirm all members of team are present. Confirm cross-team coverage of urgent patient issues and patient message capture during protected time.

A3.1.2. Confirm all needed lists are present to review.

A3.1.2.1. Code 31 - Mobility Restricted Airmen

A3.1.2.2. Code 37 - Airmen who do not meet retention standards

A3.1.2.3. Code 81 - Pregnant Airmen

A3.1.2.4. Code DW – Deployable With Limitations

A3.2. Review each list.

A3.2.1. Discuss each member to maximize deployability.

A3.2.1.1. Review basis of last clinical update. Last time member was seen.

A3.2.1.1.1. Face-to-face in clinic?

A3.2.1.1.2. Other than face to face (virtual, telecon, secure message).

A3.2.1.1.3. Last time member saw a specialist.

A3.2.1.1.4. Assess outcome from that visit.

A3.2.1.1.5. What is the next forecasted decision point?

A3.2.1.2. Current clinical status.

A3.2.1.2.1. Any change since last encounter?

A3.2.1.2.2. Any specific barriers to care/medical resolution?

A3.2.1.2.2.1. Discuss plans to overcome those barriers.

A3.2.1.2.3. If on code 31, how close to resolving issue and returning to full deployability, or needing to recommend for code 37?

A3.2.1.2.4. If on code 37, how close to clinical stability (medically stabilized and recovery relatively predictable) to write the NARSUM?

A3.2.1.2.5. If on code 37, and NARSUM already submitted, any additional clinical support required?

A3.2.2. Determine Team taskings.

A3.2.2.1. Which Airmen require an appointment for a face to face visit, phone call or secure message?

A3.2.2.2. Which Airmen require involvement by other MDG team members (e.g. case manager, Utilization Manager, referral management, PEBLO, MH, physical therapy, etc.)?

A3.2.2.3. Which cases require specific communication with member's commander?

A3.2.3. Assign Team taskings among core team for completion or coordination. Accomplish and document care plan or update for all Airmen that have not had a visit or communication in the prior 30 days.

A3.3. Communicate with Airmen, make appointments for Airmen as work assigned above.

A3.3.1. Document in electronic medical record after each encounter/communication.

A3.4. Communicate with other members of MDG as determined/indicated.

A3.5. Communicate with specialty providers involved with care.

A3.6. Communicate with commanders.

A3.6.1. Schedule regular meetings with commanders.

A3.7. Prepare for AMRO board.

A3.7.1. Document in ASIMS comments section of AF Form 469 the a brief status of each MR member.

A3.7.2. Prepare to discuss with SGP/SGH what each Airmen needs (for example; list not all inclusive):

A3.7.2.1. Change in MR code (e.g. code 31 to code 37, or removal of code 31).

A3.7.2.2. Determination if member still meets medical standards.

A3.7.2.3. Help in reaching commanders for communication.

A3.7.2.4. Any other help overcoming barriers to care.