RETURN TO FLIGHT AND SPECIAL OPERATOR DUTY GUIDANCE POST SARS-CoV-2 INFECTION*			
CATEGORY	**ATC/GBO**	**FC II/III/SWA**	**High-Performance Aircraft & Aircrew Requiring Routine Use of Aviator Mask**
SARS-CoV-2 Positive Not Requiring Hospitalization **(Asymptomatic infection and mild COVID-19)**	The following criteria suggest return to full duty is reasonable: - CDC Guidelines for Discontinuation of Isolation[1] PLUS: Clinical evaluation - Confirming no cardiac or respiratory symptoms or limitations (e.g., chest pain, palpitations, shortness of breath, exercise intolerance, etc.)[2] Physical exam - Normal respiratory, cardiac, neurologic and ENT exam - Normal vitals- BP, HR, Sp02>94% - Normal exertional pulse oximetry[3]	The following criteria suggest return to full duty is reasonable: - CDC Guidelines for Discontinuation of Isolation[1] PLUS: Clinical evaluation - Confirming no cardiac or respiratory symptoms or limitations (e.g., chest pain, palpitations, shortness of breath, exercise intolerance, etc.)[2] Physical exam - Normal respiratory, cardiac, neurologic and ENT exam (including assessment for valsalva and anosmia) - Normal vitals- BP, HR, Sp02>94% - Normal exertional pulse oximetry[3] PLUS: - Normal/normal-variant ECG[4] (add troponin if CP symptoms were experienced[5])	The following criteria suggest return to full duty is reasonable: - CDC Guidelines for Discontinuation of Isolation[1] PLUS: Clinical evaluation - Confirming no cardiac or respiratory symptoms or limitations (e.g., chest pain, palpitations, shortness of breath, exercise intolerance, etc.)[2] Physical exam - Normal respiratory, cardiac, neurologic and ENT exam (including assessment for valsalva and anosmia) - Normal vitals- BP, HR, Sp02>94% - Normal exertional pulse oximetry[3] PLUS: - Normal/normal-variant ECG[4] (add troponin if CP symptoms were experienced[5]) - Normal pre-/post-BD spirometry[6] if CP symptoms were experienced
COVID-19 Requiring Hospitalization **(Moderate or severe COVID-19)**	The following criteria suggest return to full duty is reasonable: All clinical and physical exam criteria above.	The following criteria suggest return to full duty is reasonable: All clinical and physical exam criteria above. PLUS: - Normal ECG[4], troponin and echocardiogram or cardiac MRI[7] - Normal full PFTs with DLCO[6,8] - No disqualifying abnormalities on CBC & CMP if abnormal during hospitalization[9]	The following criteria suggest return to full duty is reasonable: All clinical and physical exam criteria above. PLUS: - Normal ECG[4], troponin and echocardiogram or cardiac MRI[7] - Normal full PFTs with DLCO[6,8] - No disqualifying abnormalities on CBC & CMP if abnormal during hospitalization[9]
COVID-19 complicated by myocarditis or SARS CoV-2 Critical Illness (Respiratory failure, septic shock, and/or multiple organ dysfunction)	Some significant complications of COVID-19 such as myocarditis, deep venous thromboembolism, stroke, and myocardial infarction may be independently disqualifying and require aeromedical waiver. See relevant waiver guides.	Some significant complications of COVID-19 such as myocarditis, deep venous thromboembolism, stroke, and myocardial infarction are independently disqualifying and require aeromedical waiver. See relevant waiver guides.	Some significant complications of COVID-19 such as myocarditis, deep venous thromboembolism, stroke, and myocardial infarction are independently disqualifying and require aeromedical waiver. See relevant waiver guides.

***** Reference DoD Covid-19 Practice Management Guide for fitness profile guidance.

1. IAW CDC return-to-work guidance for non-hospitalized patients (https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html) or hospitalized patients (https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html).

2. Recommend review for other non-respiratory COVID-19 symptoms of aeromedical significance, such as anosmia, fatigue, anorexia, headaches, weakness and myalgia.

3. Exertional pulse oximetry is recommended to evaluate for persistent pulmonary dysfunction following resolution of SARS-CoV-2 infection. Multiple exertional tests are utilized in community practice to monitor exercise capacity (e.g., 1-min sit-to-stand test, 6-minute walk test, 40-step test, etc.) in chronic lung disease. These tests are now being utilized to assess for the presence of pulmonary dysfunction in individuals with SARS-CoV-2 infection even if clinical symptoms are absent. Abnormal exertional pulse oximetry (i.e. fall of 3% or more in pulse oximetry reading on exercise) should result in continued DNIF/DNIC until resolution of the exertional pulse oximetry dyscrasia. Further evaluation is recommended to ensure resolution of acute illness and exclude underlying pulmonary dysfunction that may be disqualifying. (See comments under Section 6 and 8) https://www.cebm.net/covid-19/what-is-the-efficacy-and-safety-of-rapid-exercise-tests-for-exertional-desaturation-in-covid-19/

4. ECG is indicated to screen for cardiac abnormalities, which have been documented clinically in up to 20% of all cases and objectively (via cardiac MRI) in up to 80% of symptomatic COVID-19 cases. Abnormal ECG should prompt further evaluation with troponin and echocardiogram or cardiac MRI. Additional work-up may be warranted for specific abnormalities identified on ECG. ECGs and any other cardiac studies should be forwarded to the Aeromedical Consultation Service ECG Library for review and image storage per AFI 48-123. See "ECG Findings Disposition" at https://kx.health.mil/kj/kx5/AeromedicalConsultationSvc/Pages/home.aspx

5. Individuals who experienced cardiac symptoms (e.g. dyspnea, exercise intolerance, chest pain, palpitations, syncope, etc.) during acute illness may be at higher risk for underlying cardiac dysfunction and warrant further evaluation.

6. Spirometry testing is recommended to evaluate for pulmonary dysfunction (i.e., obstruction or restriction), which has been noted to persist even after cardiopulmonary symptoms (dyspnea, cough, exercise intolerance, chest pain, etc.) resolve following SARS-CoV-2 infection. Abnormal spirometry should prompt continued DNIF and further evaluation with full PFTs to include lung volumes and DLCO. (See comments under Section 8.)

7. SARS-CoV-2 infection is associated with direct and indirect cardiotoxicity. Transthoracic echocardiogram (TTE) and/or cardiac MRI are used to evaluate the degree of cardiac involvement in symptomatic or hospitalized individuals and to further evaluate individuals with an abnormal ECG and/or troponin elevation.

8. Pulmonary dysfunction has been documented beyond resolution of COVID-19 symptoms. Individuals who were hospitalized are at higher risk for more significant lung damage, predisposing to hypoxia at altitude. Restriction and/or low DLCO on PFTs may indicate the presence of parenchymal lung damage (pulmonary fibrosis, ground glass opacities, etc.). Persistent pulmonary abnormalities may be disqualifying IAW MSD, 13 MAY 2020, G28 and warrant further evaluation (e.g., imaging, pulmonology consultation).

9. If abnormal laboratory testing or organ dysfunction were present during hospitalization (anemia, renal injury, liver injury, etc.), repeat laboratory studies should be obtained to ensure resolution. Persistent abnormalities identified on CBC or CMP warrant further evaluation and may be disqualifying. See "Aerospace Medicine Waiver Guide" at https://kx.health.mil/kj/kx7/WaiverGuide/Pages/home.aspx.

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