DEPARTMENT OF THE AIR FORCE
AIR FORCE RESERVE COMMAND

2 March 2022

MEMORANDUM FOR AEROSPACE AND OPERATIONAL MEDICINE (AOM) RESERVE MEDICAL UNITS

FROM: HQ AFRC/SG3P
549 Pine St
Robins AFB GA 31098-1635

SUBJECT: Air Force Reserve Command, Aerospace and Operational Medicine (SG3P) and Physical Exams and Standards (SGO) Tactical Implementation Guide (Version 2)

1. The Tactical Implementation Guide (TIG) supersedes the AFRC/SGO TIG Version 1.2 dated 8 November 2019. This document should be reviewed in its entirety and is the foundation for the unit level execution of the Aerospace Medicine Enterprise (AME) mission inherent within Reserve Medical Units (RMUs) with FFDAF, FFDAG and FFABC Unit Type Codes (UTCs).

2. This guide has been organized by chapters addressing every AFI, AFMAN or DAFMAN containing some element of AOM program guidance. If Air Force Reserve (AFR) specific procedures, guidance, or interpretation is required, the specifics will be outlined here. This document should be used in coordination with the governing guidance, not as a replacement or in lieu of other regulation.

3. The AFRC/SG3P and SGO Tactical Implementation Guide (TIG) is not policy and does not supersede any published policy, DODI, DHA-PI or AF direction and should not be used as such. The TIG is a flexible and easily adaptable document that will be updated as needed when policy changes or new policies are implemented. When updates occur, a summary of revisions and a new dated version of the TIG will be posted. The most current version will be maintained on the AFRC/SG3P Knowledge Exchange (KX).

4. Recommended additions, corrections, or questions may be submitted to the AFRC/SG3P mailbox at afrc.sgp@us.af.mil

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Tactical Implementation Guide (TIG)
Version 2

2 March 2022

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Introduction

1. Purpose. During Unit Training Assemblies (UTAs), the primary mission of Air Force Reserve Medical Units (RMUs) with the AOME mission set is to train and provide physical exams/IMR services, complete Non-Duty Disability Evaluation (NDDES), occupational health assessments, deployment health screenings, and all other AOME processes for their supported Reserve Wing and Geographically Separated Units physically located at their location. Professional Staff (Pro-Staff, e.g., physicians, physician assistants, nurse practitioners, nurses, dentists, optometrists, etc.) and medical technicians are prohibited from providing routine medical/dental care and non-military exams during Unit Training Assemblies, Annual Tour/Training or RPA status while not under the credentialing authority of an Active Duty (AD) Military Treatment Facility (MTF). Care for Reserve Component Service Members (RCSMs) in these instances should be obtained from their private health care providers. Unless a Reservist is on Extended Active Duty (EAD), all non-emergency, routine military healthcare is limited to what is necessary to prevent pain and undue suffering until the member can reasonably be referred to their civilian provider. Emergent care provided by the RMU is limited to Self-Aid and Buddy Care (SABC)/Basic Life Support (BLS) until arrival of Emergency Medical Services (EMS). Access to EMS or Urgent Care off-base should not be delayed by sending members to the RMU. Access to care benefits and entitlements for RCSMs will be addressed in further detail in AFMAN 41-210, *TRICARE Operation and Patient Administration Functions*.

2. Reserve Medical/Dental Care Procedures.

A. Ambulance. Most RMUs do not have an ambulance assigned to their equipment inventory nor is there any requirement to have or maintain such equipment. RMUs which have an ambulance included in their equipment inventory may only use it for training purposes.

B. Sick Call. Sick call is not provided by RMUs. Commanders should notify the RMU when Emergency Medical Services (EMS) or Urgent Care is utilized to facilitate proper documentation in the medical record and initiation of Line of Duty (LOD) and Medical Eligibility Verification with the Defense Health Agency (DHA) to facilitate ER bill claims and pre-authorization for follow up care stemming from a LOD. Service Member (SM) should tell facility to "manually bill TRICARE". RMUs should be proactive and engage the applicable ADMTF office to establish local procedures as well. The DHA website has extensive information, guidance, procedures, contacts and forms to assist RCSMs and RMUs in this process.

Note: *AFR members should not be referred to the RMU when sick or injured. Reservists unable to complete the UTA will be deferred to their Commander (or Individual Augmentee Program Manager for IMA personnel). Members must follow up with their private healthcare provider (HCP) and ensure that a copy of the associated HCP clinical documentation is provided to the RMU to determine future fitness for duty IAW DAFMAN 48-123 para 9.3.*

3. Credentials. Within the RMU, military providers are privileged to provide physical exam support only.

A. Privileging for professional staff at collocated RMUs may include providing medical treatment in ADMTFs. Such treatment will only be provided to eligible beneficiaries while the AFR military provider is covered under the ADMTF credentialing authority.

B. Reserve providers are NOT privileged during the UTA weekend to provide emergency medical treatment or base-wide emergency medical coverage/response while performing duty (UTAs, man-days, Annual Tour [AT], etc.) at their home duty station. Only SABC/BLS augmented with Automatic External Defibrillating (AED) is authorized.

C. Reserve providers are covered for mission-required immunizations, administration of drugs for reactions to immunizations, and to provide medications required for prophylaxis during deployment or operational support. This is consistent with the scope of care reflected on the *Physician's Master Privilege List* as used in CCQAS.

D. Credentialing and Privileging Issues. IAW AFI 44-119, *Medical Quality Operations*, Reserve providers in a deployable Unit Task Code (UTC) are required to maintain a set of military privileges in the specialty corresponding to their duty AFSC, or the AFSC that allows them to substitute within their UTC (IAW applicable Mission Capability [MISCAP]). All Reserve providers need to maintain a UTA privilege list as defined on the *Physician's Master Privilege List* as used in CCQAS.

E. The management of the credentialing and privileging process must be under the professional oversight of a senior physician, the Chief of Professional Staff (SGH), in the RMU. This senior physician is, in turn, privileged by the ADMTF/CC (if collocated) or by the AFRC/SG3P (if the RMU is not collocated with an (ADMTF). All providers are responsible for reviewing and understanding the application of UTA privileges. Practice outside the UTA scope can result in loss of privileges.

4. Air Force Instructions. Each of the Air Force Instructions (AFI) in this guide can be found on Air Force E-Publishing (E-Pubs). All AFIs in this guide will be reviewed and referred to when the RMU is completing AOME functions. http://www.e-publishing.af.mil

Chapter 1
AFI 10-250, *Individual Medical Readiness*

1. References / Further Reading.

A. DoD Directive 6200.05, *Force Health Protection Quality Assurance (FHPQA) Program*

B. DoD Instruction 6025.19, *Individual Medical Readiness*

2. Self-Assessment Communicators.

A. 10-250, Individual Medical Readiness, Unit/CC

B. 10-250, Individual Medical Readiness, Medical Unit

C. 10-250, Individual Medical Readiness, Installation CC

3. Introduction. This Air Force Instruction (AFI) establishes defined, measurable medical elements, criteria and goals for medical readiness for Active and Selected Reserve (SELRES) members of the Air Force (AF) and participating individual ready reservists. Current policy (DODI and AFI) provides no current definitive IMR standard as it pertains IMR and PMC rate and expectations. However, to further improve Individual Medical Readiness (IMR) compliance above the previous AF goal of 80%, pending updated policy/standards, Reserve Wings, Groups, and Units should bring their Actionable IMR (A-IMR), which are the Partially Mission Capable (PMC) items, to 5% or less. Improving PMC will lead to improved IMR compliance. AFRC unique actionable IMR reports are available via ARCNET – Readiness – Commander Actionable IMR, to all users, medical and non-medical.

4. Guidance.

A. Air Force IMR. The previous compliance goal was 80%. IMR and PMC rates are centrally computed and reported within the AF authoritative data system ASIMS/AFCHIPS.

B. Partially Mission Capable (PMC). PMC is defined as unmet IMR requirements that the member may generally resolve within 30 days and should be <5%. For example, if a member is overdue for their seasonal flu immunization, they can easily report to the Reserve Medical Unit for the vaccination. AF Commanders may monitor their Wing, Group, and Unit-specific A-IMR, (i.e., PMC) compliance rate at any time at the URL above. PMC incorporates 5 of the 6 IMR requirements, excluding the Duty Limiting Conditions (DLC). Members overdue for any IMR requirement are deemed non-compliant and will be processed as outlined in Chapter 7 of this guide. Of note, while in some reports PMC is color coded as 'yellow', IMR is a measure of the number of members that are 'GREEN', and if they are not green then they are 'RED'. Being red

may be separately broken out as Not Mission Capable (Members on a DLC) or because of a PMC item, but both are note ready/not green and therefore are 'red'. PMC break out color coding as yellow should not be mistaken for being 'ready', an overdue IMR item (PMC) is not ready (red), these items are:

i. Lab work (e.g., HIV test every two years)

ii. Annual dental exam

iii. Annual Preventive Health Assessment (PHA)

iv. Immunizations

v. Equipment (e.g., eyeglass inserts for gas mask)

C. AFCHIPS. This is the definitive central repository that calculates IMR and PMC rates/data and receives input from both ASIMS and MilPDS. It is at the AFCHIPS level that students, deployed personnel, and personnel pending separation and involuntary IRR are removed from the IMR equation based on their DAV code.

i. FMC = Fully Mission Capable. Capable of deploying with no medical action required. (Green)

ii. PMC = Partially Mission Capable. Members who are not on a Mobility Restricting (MR) Duty Limiting Condition Report (DLC). Members have unmet IMR requirements that can generally be resolved within 30 days. (Red)

iii. NMC = Not Mission Capable. Members on a mobility restriction profile including short-term mobility restrictions, AAC 31, 37 or 81, or ALC 1 = X, 2 = Y or 3 = C. (RED).

D. Members Deferred from IMR Calculation. Certain members based on assigned DAV code are NOT calculated when IMR rates are rolled up to AFCHIPS. Below is an example of how specific personnel types affect IMR and reflect important categories that are not included in IMR reports.

Note: *While these members will not count for IMR in AFCHIPS, they will populate in ASIMS.*

Personnel Type	FSS Required Documentation	Required Personnel Transaction	IMR Impact
Pending Discharge	Discharge Package	**MilPDS Duty Status Code** (28) – *Pending Separation, Under Investigation*	• **Will not count as part of your unit's IMR population**
Involuntary Separation to IRR	AF Form 1288 - Involuntary Separation Package		
Retirement	*Retirement Order generation triggered*	**Records Status Code** **(20)** - *Active Projected Separation, No Projected Assignment*	
Voluntary Assignment to IRR	*Unit/CC assure member has current IMR criteria before excusing from participation while awaiting IRR assignment!*	**Duty Status Code** **(00)** - *Present for Duty (eligible for deployment)*	• ***Continue to count against IMR while awaiting IRR assignment***
Deployment	*Must perform medical **pre-deployment** out-processing through Reserve Medical Unit in order for RMU to create ASIMS deployment record*	***ASIMS deployment record must be created to generate Duty Status Code 20; effective on projected departure date*** *Deployment dates determinate*	• ASIMS Visible • "Metrics" = N • **Will not count as part of unit' IMR population** • ***Expires 90 days from deployment return date***
BMT or Initial[1] Tech School	**BMT / Tech School Orders** *This transaction is performed at Force Support Squadron during the trainees' BMT and Tech School in-processing & out-processing*	**MilPDS Duty Status Code[2]:** • **(11)** - *Assigned but Not Joined* **AND** **Reserve Section Code (CH)** *or* **(CD)** ***OR*** • **(12)** - *Accessed Not Joined, TDY En Route, Re-Initial Active Duty Training* **AND** **Reserve Section Code (CH)** *or* **(CD)**	• ASIMS Visible • Assigns to Student (STU) evaluated population. • Will see in your IMR personnel list, with "Status" column = "STU" • **Will not count as part of your unit evaluated population**

E. AFCHIPS Report Hierarchy. When pulling IMR statistics from AFCHIPS there are two options to choose from that communicate two uniquely different reports depending on location.

i. Report titled "Air Force Reserve". This report is sorted by medical units and reports the IMR rate for all units supported by the RMU and if support is provided to GSUs it is here they will be included. This report should be monitored by the AMRO/DAWG and AMC. Some of the units listed in this report that you provide medical support for may not actually belong to your Wing, though you are the supporting RMU responsible/accountable for their IMR.

Note: *Per 48-133, Chapter 4, the DAWG still exists to collect and report various metrics such as, IMR, PMC rates, etc. to be reported to AMC and EMC.*

ii. Report titled "Air Force Reserve NAF". This report is sorted by NAF and Wings and represents the IMR rate that the NAF/CC, Wing/CC, or Group/CC is responsible for. If the medical squadron supports a GSU that the Wing/CC does

not own, they should not be listed here. This report is the most accurate one to present to the Wing/CC as it represents what he/she is responsible/accountable for.

Note: *For some, these reports will look the same, but if you have a GSU that is not technically part of the Wing it is important to know the difference and report the correct one to the Wing/CC.*

F. IMR Math Example. Each category of the IMR stands alone and is based on the number of members available based on adjusted population within the unit once valid DS or DAV coded members are removed from the equation as noted above.

i. Example of a unit with 100 members available.

a. 5 members need PHA

b. 5 different members need dental

c. 5 different members need labs

d. 5 different members need vaccines

e. 5 different members need gas mask inserts

f. 5 different members have AAC 31 or AAC 37

g. 5 + 5 + 5 + 5 + 5 + 5 = 30 members not ready!

h. Therefore, in each category, 95/100 = 95%

i. Therefore, 70/100 = 70% overall IMR rate.

ii. While a single member may be deficient in multiple categories and will affect each category separately, a single member will only negatively affect overall IMR once.

Chapter 2
AFI 10-403, *Deployment Planning and Execution*

1. References / Further Reading.

A. AFI 10-250, *Individual Medical Readiness*

B. AFI 36-3103, *Identification Tags*

C. AFI 41-106, *Medical Readiness Program management*

D. DAFI 48-122, *Deployment Health*

E. DAFMAN 48-123, *Medical Examinations and Standards*

F. DODI 6490.03, *Deployment Health*

G. DODI 6025.19, *Individual medical Readiness*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This AFI covers Medical Clearance and Deployment Health Assessment Requirements. The information in this AFI also provides guidance for those that require deployment waivers.

4. Guidance.

A. Deployment-Related Health Assessments Program. AFRC/SG3P will no longer maintain an extensive folder on the KX with tools in support of the DRHA program. Instead RMUs should bookmark and refer to the **AFMRA DRHA Program Office KX**. The AFMRA DRHA Program Office is the primary content generator and subject matter experts for this program. Tools and resources that will assist RMUs in the tactical level execution of the DRHA program will be found here. AFRC/SG3P routinely coordinates and reviews AFRC specific products with the AFMR DRHA Program Office for utility in AFR RMUs and AFR specific documents are available. AFRC/SG3P will only host AFRC specific guidance/direction in the TIG or on the AFRC/SG3P KX, which should be minimal.

B. Red Medical Alert Identification (ID) Tag Requirement. See the AFRC/SG3P KX – Deployment Health Folder for the latest version and guidance.

C. AFRC Deployer DRHA completion.

i. Log on to MyIMR at https://asimsimr.health.mil/imr/myIMR.aspx

ii. Scroll to the bottom of the MyIMR webpage

iii. Select Return to the Directory

iv. Complete the online DRHA questionnaire (answer ALL questions)

v. For DRHA 3, contact Reserve Health Readiness Program (RHRP) contracted call center Logistics Health Incorporated (LHI) at 1-888-734-7299 to speak with a healthcare provider and accomplish your required medical encounter over the phone. The LHI call center is open 24/7.

Note: *Steps i and ii require CAC.*

Chapter 3
AFI 10-2519, *Public Health Emergencies and Incidents of Public Health Concern*

1. References / Further Reading

A. DoDI 6200.03, *Public Health Emergency Management Within the Department of Defense*

B. DoDI 6440.03, *DoD Laboratory Network (DLN)*

C. GCP PI&ID 3551-13, *Department of Defense Global Campaign Plan for Pandemic Influenza and Infectious Disease*

D. Air Force Policy Directives (AFPD) 10-25, *Emergency Management*

E. AFPD 10-25, *Emergency Management*

F. AFPD 10-26, *Counter-Chemical, Biological, Radiological, and Nuclear Operations*

G. AFMAN 10-2608, *Disease Containment*

2. Self-Assessment Communicators

A. 10-2519 Public Health Emergencies and Incidents of Public Health Concern

i. Collocated installations: No – This communicator will be completed by the Host MTF

ii. AFRC installations: Yes - Bioenvironmental Public Health office completes communicator and Public Health Emergency Officer PHEO within the Reserve Medical Unit validates communicator

3. Introduction.

A. This document provides guidance to protect Air Force-led installations, assets, personnel, and base population in the event of a public health emergency or incident of public health concern.

4. Guidance

A. Bioenvironmental Public Health (BEPH) Office

i. In most situations, the BEPH Office supervisor should perform the critical duties of the "Medical Emergency Manager" (MEM), in coordination with the Public Health Emergency Officer (PHEO). If the PHEO is a

Traditional Reservist (TR), it is possible the PHEO will not have the appropriate amount of time to devote to assisting the BEPH office in the MEM roles. In those situations, the Senior Medical Air Reserve Technician (ART) should assist the BEPH office, when applicable.

ii. The BEPH Office supervisor should be the Subject Matter Expert of the Disease Containment Plan (DCP), however the resources reside in the Reserve Medical Unit and therefore, require collaboration of both agencies.

B. Public Health Emergency Officer (PHEO)

i. For those AFRC installations that have a full-time AGR provider (Nurse Practitioner, Physician Assistant, Physician), the medical group commander should recommend this member as the primary PHEO to the wing commander for appointment. If the primary PHEO is not a physician, the alternate PHEO (TR) should be a senior medical corps officer.

ii. For a template of the wing commander, PHEO appointment letter, see Attachment 16.

C. See AFI for further guidance.

Chapter 4
AFMAN 11-402, *Aviation and Parachutist Service*

1. References / Further Reading.

A. DAFMAN 48-123, *Medical Examinations and Standards*

B. AFI 48-170, *Preventive Health Assessment*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This AFI sets the procedures for initiating aviation/parachutist service, awarding Air Force aeronautical ratings and aviation badges, and gives guidance that applies to administering initiation and termination of aviation/parachutist service and award of ratings/badges. It applies to all US Air Force flight managers, Commanders of flying units, and aircrew personnel. This publication applies to Air Force Reserve Command and the Air National Guard.

4. Guidance. See this AFI for applicable information. AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 5
AFI 31-117, *Arming Use of Force (AUoF) by Air Force Personnel*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

B. AFI 10-250, *Individual Medical Readiness*

C. DAFMAN 48-123, *Medical Examinations and Standards*

D. AFGM to DoDM 5210.42_AFMAN 13-501, *Nuclear Weapons Personnel Reliability Program (PRP)*

2. Self-Assessment Communicators.

A. 31-117 - *Arming and Use of Force by Air Force Personnel (Medical PRAP)* Ground RMU with Aerospace Medicine Enterprise UTC mission that also support a Security Forces Squadron

3. Introduction. This instruction also defines reliability criteria for AF Security Forces. The RMU/SGP will ensure immediate notification to the patient's commander, or designated command representative, when a condition is identified that can impair a Security Forces member's ability to safely perform armed duties.

4. Guidance.

B. The following links will be used to develop and maintain the Arming Use of Force program within the RMU.

i. AFRC/SG3 PRAP KX, tool and templates.

ii. HAF/A10 - AF Personnel Reliability Program (PRAP), training and policy.

iii. Air Force Security Forces SMART Net website.

C. Nine essential elements, outlined in the Policy center on two fundamental questions of a reliability program.

i. Can I screen you?

ii. Once screened, can I continuously monitor you?

a. Those who are AGR and at BOS assignments will be continuously monitored.

b. Those who are assigned to CATM will also be continuously monitored.

Note: *AUoF applies to 31P and 3P0 Reservists who have potential to arm, based on the arming group within the AFI, will be continuously monitored when tasked for specific duties. Examples: Aircrew, Weapons Transport, Deployers with specific line remarks for weapon related duties, etc.*

D. Provider Responsibilities. Any time a provider (includes specialists) identifies any medical or mental condition, or treatment that may interfere with a defender's reliability to safely bear arms, they need to let that member's Commander (or designated representative) know of the condition.

i. The commander (or arming rep, if designated) will evaluate the information and decide whether that member can carry a firearm or requires altered duties.

ii. The provider is expected to make an immediate notification **and** complete an AF Form 469.

iii. Clinical Support Staff can assist with the notification and AF Form 469.

E. In Between UTA Procedures when no Provider is available. 1st option is to coordinate with host ADMTF for a provider review and potential DO NOT ARM notification. RMUs that do not have access to an ADMTF will utilize the full-time staff to make the DO NOT ARM notification and consult with AFRC/SGP by sending an email to the org box at afrc.sgp@us.af.mil. The email to the AFRC/SGP org box should occur at the same time as notification to the SFS/CC or designated representative. RMUs should strive to ensure support between UTAs for the AUoF program is part of the host tenant support agreement.

Chapter 6
AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted)*

1. References / Further Reading.

A. DAFMAN 48-123, *Medical Examinations and Standards*

B. AFMAN 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Aviation Badges*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This AFI implements classification procedures and related actions for Air Force officers and enlisted. The medical standards requirements for entry to all AFSC for officers and enlisted are covered by this AFI. The policy to waive these requirements can be found in Table 3.1 and Table 3.2. Reference AFOCD and AFECD for AFSC specific requirements, which is sited in paragraph 1.2.2. and available via My Pers.

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 7
AFMAN 36-2136, *Reserve Personnel Participation*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

B. AFI 36-2110, *Total Force Assignments*

C. AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*

D. AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members*

E. AFI 36-3208, *Administrative Separation of Airman*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. The Reserve Personnel Participation Regulation is inherently a Personnel (FSS/A1) program, however a few extremely important SG elements regarding medical qualifications for participation, compliance with medical requirements/standards are covered and all RMUs need to familiarize themselves with this content.

A. Members placed on Duty (DR), Mobility (MR) or Fitness (FR) restrictions via an AF Form 469 may participate for pay or points at the discretion of the Unit Commander. RMUs must clearly communicate duty restrictions in support of Commanders making informed decisions on member participation and duties.

B. This DOES NOT apply to members in Non-Compliance for overdue medical/dental requirements as covered in AFMAN 36-2136 and DAFMAN 48-123. RMUs will continue to advise CCs and the FSS via memorandum (Not via an AF Form 469) as noted in this Tactical Implementation Guide (TIG), of personnel not meeting individual medical readiness requirements for placement into NPNP.

4. Guidance.

A. Non-Compliance If a member has any expired IMR requirement, overdue ALCs resulting from the members failure to provide appropriate medical records or ROI or fails to submit documentation to support processing of any medical assessment, the member will be deemed non-compliant, and a Memorandum for Record (MFR) will be sent to the unit commander and MPF that will notify the CC and FSS of requirement for Medical Qualifications noted in AFMAN 36-2136. Document the member's non-compliance and delinquency with medical/dental requirements in the member's service treatment record (STR) and AMRO Board minutes/notes if applicable.

B. Expired IMR Requirements. AFRC members who have expired IMR requirements are referred to their Commanders IAW AFMAN 36-2136 and DAFMAN 48-123. The actions to be taken are detailed below.

i. Generate the Non-Compliance MFR (Attachment 9) and send to member's commander and the MPF to update the Duty Status code.

ii. Place the MFR in the member's medical record and upload to EHR.

iii. Once all IMR requirements are met, members may be released from non-compliance via RMU issuance of MFR (Attachment 10).

C. Management of Expired ALC. Members with expired ALCs are medically disqualified for continued military duty. It is the member's responsibility to obtain and provide copies of all civilian medical records to facilitate case processing. To assist with obtaining all records, it is recommended for the member to be provided a DD Form 2870 to fill out/submit to each of their civilian providers so that their records can be submitted to the RMU to renew the ALC/Retention Waiver. Those SMs who have failed to comply will be referred to their Commanders for processing IAW AFMAN 36-2136 and DAFMAN 48-123. If the member has complied with the RMU's requests for appropriate medical documentation, and the overdue ALC is no fault of the member's: A new AF Form 469 will be issued (with no change to the AAC) and will indicate the expired ALC, with the member restricted to UTA and AT at home station only, while the renewal case is submitted and adjudicated by AFRC/SGO.

i. If the member HAS NOT complied with submitting the necessary documentation from their civilian providers to the RMU in a timely manner (see DAFMAN 48-123), the member will be placed in non-compliance status following the actions detailed below:

a. Generate the Non-Compliance MFR (Attachment 9) and send to member's commander and the MPF to update the DS code.

b. Place the MFR in the member's medical record and/or upload to EHR.

c. The RMU will update the current AF Form 469 adding the following statements to the top of the REMARKS section; *"Member's ALC Retention waiver has expired, notification of member non-compliance sent to CC and FSS on (date), IAW AFMAN 36-2136 and DAFMAN 48-123."*

d. The member will not be released from non-compliance status until the RMU has received the necessary records to process the ALC Renewal case. Once the member submits required documents the RMU will issue the release from non-compliance memo (Attachment 10).

D. Member Non-Compliance on AAC. Members who are already on an AAC 31, 37, or 81 and are non-compliant with RMU requests for supporting medical records or signed DD Form 2870(s) (ROI) will be referred to their Commanders for processing IAW AFMAN 36-2136 and DAFMAN 48-123.

i. A member with a known, unknown, or questionable medical or dental condition who refuses to comply with a request for medical information or evaluation is considered medically disqualified for continued military duty and the RMU will follow the actions detailed below:

a. Generate the Non-Compliance MFR (Attachment 9) and send to member's commander and the MPF to update the DS code.

b. Place the MFR in the member's medical record and/or upload to EHR.

c. The RMU will use the following statement at the top of the remarks section in the MFR: *"Member has failed to provide the necessary medical records to either release them from their AAC or continuing processing their fitness for duty evaluation and should be treated as non-compliant and considered for administrative separation by the commander IAW AFMAN 36-2136 and DAFMAN 48-123."*

d. The member will not be released from non-compliance status (Attachment 10) until the RMU has received the necessary records to further evaluate the condition and/or process the required fitness for duty evaluation.

e. The applicable AAC will be continued in ASIMS until such time as the RMU can either verify resolution of a temporary limiting condition (AAC 31 or 81) or process the fitness for duty evaluation with a resulting return to duty determination in the case of an AAC 37. Entries in the AMRO minutes should reflect the deferral of the case to the unit/CC for action.

DI. Non-Compliance for Documentation Request. Members who have failed to provide clinical/medical treatment records when not yet on an AAC 31 will be referred to their Commanders for processing IAW AFMAN 36-2136 and DAFMAN 48-123.

i. A member with a known, unknown, or questionable medical or dental condition who fails to comply with a request for medical information or evaluation is considered mobility restricted and will be placed on an AAC 31 to reflect such. The RMU will follow the actions detailed below in addition to generating the AF Form 469 with the AAC 31:

a. Absent records to the contrary the RMU should presume worst case scenario and err on the side of caution and apply stringent duty and fitness restrictions to the AF Form 469.

b. Generate the Non-Compliance MFR (Attachment 9) and send to member's commander and the MPF to update the DS code.

c. Place the MFR in the member's medical record and/or upload to EHR.

d. The RMU will use the following statement at the top of the remarks section of the MFR: *"Member has failed to provide the necessary medical records and therefore is not medically qualified for continued military service and should be treated as non-compliant and consider for administrative separation by the commander IAW AFMAN 36-2136 and DAFMAN 48-123."*

e. The AAC 31 will be continued in ASIMS until such time as the RMU can either verify resolution of the limiting condition or determine an I-RILO and conversion of the AAC to 37 is warranted. Entries in the AMRO minutes should reflect the deferral of the case to the Unit/CC for action until either of these have occurred.

F. No Show for Medical/Dental Appointments for Fitness for Duty Evaluations. AFRC members who fail to show for medical/dental appointments related to processing their fitness for duty evaluation case are non-compliant and will be referred to their Commanders for processing IAW AFMAN 36-2136 and DAFMAN 48-123.

i. A member who fails to show for required appointments necessary to process a fitness for duty evaluation case is considered non-compliant and the RMU will the follow the actions detailed below:

a. Generate the Non-Compliance MFR (Attachment 9) and send to member's commander and the MPF to update the DSC.

b. Place the MFR in the member's medical record and/or upload to EHR.

c. The RMU will use the following statement at the top of the remarks section in the MFR: "Member has failed to show for required medical/dental appointment and therefore is not medically qualified for continued military service and should be treated as non-compliant and consider for administrative separation by the commander IAW AFMAN 36-2136 and DAFMAN 48-123."

d. The member will not be released from non-compliance status (Attachment 9) until they report for the required evaluation and the required fitness for duty evaluation can be processed.

e. The applicable AAC will be continued in ASIMS until such time as the RMU can either verify resolution of a temporary limiting condition (AAC

31) or process the fitness for duty evaluation with a resulting return to duty determination in the case of an AAC 37. Entries in the AMRO records should reflect the deferral of the case to the unit/CC for action.

Note: *The phrase **"fitness for duty evaluation"** is an all-encompassing blanket term that includes the I-RILO, MEB/IDES, and Non-Duty Related Disability Evaluation (NDDES) cases/process. This term also includes local RMU provider reviews/determinations to issue, remove, or adjust duty/mobility restrictions or to refer members into anyone of the three more formal case processes previously mentioned.*

G. Participation Rules.

i. Per guidance disseminated 08 Feb 2019, members no longer have a no-pay/no-points status reflected on their AF469s while on an AAC 37 or 31, and the need for a Participation Waiver is not required.

a. The RMU is still responsible to ensure all appropriate Duty/Fitness Restrictions are listed on the member's AF469.

b. The member's Commander will decide the member's participation based on the documented fitness/duty restrictions, as communicated via the AF469.

c. While Commanders may allow participation, other policy or reporting instructions may restrict specific tours for which AFMAN 36-2136 is not the governing authority. Example: While the Commander can approve a member on AAC 31 or 37 to perform a 60-day RPA tour, attendance at a formal school may have set restrictions not permitting such and therefore not covered by this update to the Reserve Personnel Participation AFMAN. Simply put - other policies/reporting instructions may restrict specific duties or tours.

ii. The allowance for Dental Class 3 on an AAC 31 and pregnant members on an AAC 81 to participate, are addressed in other policy.

a. Dental is governed by AFMAN 47-101 and the Dental Guide, more information can be found here.

b. AFRCI 41-104 is rescinded. Pregnancy participation is governed by AFMAN 36-2136.

H. Extension of Military Orders for Reservists with Medical Conditions. The RMU is responsible for conveying to the immediate Commander, via an AF Form 469, a member's current medical status and whether he/she may safely perform military duty as communicated vi the duty restrictions. The RMU does not advise on whether a member can return to civilian employment. The RMU is also required to initiate an LOD for

potentially service-connected injuries or illness IAW AFI 36-2910. RMUs are not responsible for approving or disapproving extension of military orders IAW AFMAN 36-2136. The local supporting MPF is the OPR for this action. Requests for medical continuation orders resulting from a MPA tour are input by the member's unit via the M4S.

Chapter 8
AFMAN 36-2905, *Fitness Program*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. Fitness restrictions are managed IAW AFI 48-133 and documented on AF Form 469.

4. Guidance.

A. Sickle Cell Trait (SCT) – The purpose of this procedural instruction is to provide Reserve Medical Unit (RMU) staff with the guidance necessary to support changes in the Air Force Fitness Screening Questionnaire (FSQ). These changes were made to improve the safety, health, and welfare of our Airmen. As such, the FSQ includes questions to specifically address the presence of Sickle Cell Trait (SCT) and to ensure validation of the appropriate member education. This is to assist in identifying members which may need SCT counseling as well as the tools to provide said counseling if necessary.

i. Background Information - SCT is a relatively common inherited blood condition that affects about 4 million people in the United States. Individuals with SCT do not have sickle cell disease, nor will they develop sickle cell disease later in life. SCT is usually asymptomatic, but under certain circumstances, life threatening complications can occur. Strenuous exertion coupled with certain environmental and/or physical conditions increases the risk of these complications. SCT is normally not disqualifying for service or retention, but members with SCT may require activity modification and they must be aware of complications as well as the countermeasures that can be taken to prevent adverse events

ii. Screening - Members are typically screened for SCT at accession during either Basic Military Training (BMT) or upon entry into commissioned service. If positive, additional testing is performed to ensure the member does not have sickle cell disease, anemia, or additional blood disorders that might be incompatible with military service. SCT screening status (positive, negative, or unknown) can be determined by querying ASIMS. The member can query for themselves by following the link presented in the FSQ to My IMR.

iii. Counseling - If the work-up confirms the diagnosis of SCT, the member receives a video briefing that provides basic information about SCT. The member is also given an opportunity to discuss their SCT status with a medical provider. This session is noted in the member's medical record and the member signs a statement attesting to their participation in the session. This is considered the first counseling session. Members are expected to receive another session when in-processing at

their first duty station. The same procedure is followed with a video brief and opportunity for discussion with a medical provider – This is the second counseling session.

iv. Regarding SCT, the current FSQ requires the following (3) things of the member:

a. The member is aware of their SCT test result.

b. If the member has SCT, then they must have completed at least (2) counseling sessions with a health care provider.

c. If the member has SCT, then they must have watched the SCT educational video within the last year.

Note: *The member may meet the counseling session requirement by having undergone a session in their initial training (BMT or COT) and again at their first duty station. There is no requirement for an additional session. However, the member with SCT must watch the video brief on an annual basis. This brief "What the Warfighter Needs to Know About Sickle Cell Trait" may be viewed by the member at home by simply following the web link provided in the FSQ.*

v. Determining SCT Screening Status - The RMU can query ASIMS using the Medical Status reports feature. A filtered spreadsheet to identify members of the Wing that are SCT positive, or status-unknown can then be generated from this report. Please keep in mind that SCT status is protected health information and that the applicable precautions must be observed during disclosure and distribution. Providing group counseling sessions is not permitted as this could constitute a PHI breach.

vi. Additional Counseling - If a member requires a second or additional counseling session (which they might request), we recommend starting with the standard "What the Warfighter Needs to Know about Sickle Cell Trait Warfighter video brief" provided in the FSQ. There is additional material from the Human Performance Resources CHAMP This site has several different briefings, including the abovementioned Warfighter version as well as versions for First Responder and Provider. An informational pamphlet can also be distributed or displayed. We have uploaded an example from the 42 MDG at Maxwell AFB to our KX; LINK

a. RMU staff should be prepared to answer questions that the member may have about SCT. Given this, the counseling session must be administered by a medical provider.

vii. Three major points to stress in one-on-one counseling sessions:

a. Complications of SCT are avoidable with proper preparation and awareness.

b. Hydration is key. Hydration is important for all airmen engaged in physical activity, but it is especially important for those with sickle cell trait, so you do not become dehydrated.

c. Listen to your body; if something doesn't feel right stop and seek immediate care.

viii. Documentation - Following the counseling session, an entry should be made in the medical record and the member should sign a statement that they received the briefing. As an example, please see the posted SF600 overprint used for COT by the 42 MDG at Maxwell AFB on the Kx: LINK

ix. Additional Information & Considerations:

a. If a member is positive for SCT, we recommend an entry in the member's 2766 that includes not only the positive status, but also the dates of the first and second counseling sessions.

b. Consider additional counseling in pre-deployment processing, especially if the member is to deploy to an area that might have elevated SCT-related risk due to elevated temperatures and/or altitudes.

c. Asymptomatic SCT is not disqualifying for military service. However, symptomatic disease or a history of SCT related complication does require an IRILO. See Medical Standards Directory (MSD) N15

d. Aircrew with SCT do not require a waiver, but they do require one-time MAJCOM certification –See MSD N15.

x. Duty Restrictions for SCT for AF Form 469: *"Member has medical condition which could limit the individual's exercise tolerance and capacity for physical exertion. This condition also predisposes them to serious or life-threatening complications. Prior to any new activities which place member at increased metabolic stress, (such as an intense exercise regimen, manual labor at altitude, etc.) member requires an acclimation plan. Ensure adequate hydration."*

a. We recommend these members be queried annually at their PHA about their status and any symptoms related to SCT. It's an excellent opportunity to provide additional SCT counseling. The need for a recurrent annual AF 469 drives an annual review of the member's status:

b. Were there any episodes of illness suggesting symptomatic SCT?

c. Does the member understand self-management of SCT status?

xi. Education and Training CME are available on JKO and MilSuite.

Chapter 9
DAFI 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON) and Incapacitation (INCAP) Pay*

1. References / Further Reading.

A. AFMAN 41-210, *TRICARE Operations and Patient Administration Functions*

B. DODI 1241.01, *Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements*

C. DODI 6495.02, *Sexual Assault Prevention and Response (SAPR) Program Procedures*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This instruction implements Air Force Policy Directive (AFPD) 36-29, Military Standards and provides guidance for Line of Duty (LOD) determinations, as well as the procedures for retaining or ordering Air Reserve Component (ARC) members on active duty for medical continuation (MEDCON) and providing ARC members Incapacitation (INCAP) Pay.

4. Guidance.

A. Purpose. The process used to evaluate and determine if a SM is eligible for GOVERNMENT BENEFITS as the result of an illness, disease, injury, or death incurred or aggravated in a military. The four primary benefits potentially associated with a LOD are 1) Access to care via a DOD facility 2) Medical Continuation (MEDCON) orders, 3) Incapacitation Pay and 4) Disability compensation/benefits via the MEB/IDES pathway.

B. Goals of LOD Process.

i. Timely completion of the LOD.

ii. Prevent undue suffering, anxiety, and hardship for the member and family.

iii. Enter the member into the appropriate health care system (civilian or military) as soon as possible.

C. When an Informal LOD is required. LOD Guidance is driven by DoDI 1241.01 and DAFI 36-2910. An LOD is required if the following applies:

i. If the case involves EPTS conditions.

ii. For any disease process (e.g., diabetes, heart disease, cancer).

iii. If continued medical treatment will be required.

iv. If the member is likely to apply for Incapacitation Pay.

v. If an MEB is needed.

D. VA Benefits. Certain VA benefits make an LOD unnecessary.

i. Hearing Loss

ii. VA requirements for "service connection" may not be the same as the DOD requirements for Line of Duty.

E. Administrative LOD. Admin LODs are completed in lieu of an Informal LOD and are for short illnesses/injuries expected to completely resolve (e.g., cold or flu). They may also be utilized for medical conditions that EPTS and are not service aggravated, or a minor ILOD condition with no likelihood or permanent disability, hospitalization, requirement for continuing medical treatments, or a request for incapacitation pay. Items required to complete a ALOD are as follows:

i. Initial Clinical documentation and other supporting medical documentation.

a. To alleviate wait times and incomplete documentation, the member will complete a DD Form 2870, *Authorization for Disclosure of Medical or Dental Information*. (For Block 4, "PERIOD OF TREATMENT" enters from the date the condition/treatment started to an end date that will cover all treatment rendered, the current date, or "Until Revoked.") Additionally, a standardized civilian provider input forms secondary to LOD Reform initiative is forthcoming and will be posted to the AFRC/SG3P LOD program folder on KX.

b. Use AHLTA, MHS Genesis, JLV, ASIMS, composite Service Treatment Record (STR), and any other available Electronic Health Record (EHR).

ii. Status verification documentation(s) at least one of the following:

a. Certified orders: Must be certified by filling in block 36-44 of the AF Form 938. For Deployments, in addition to the AF Form 938, any: CED orders, NATO orders, etc.

b. AF Form 40A, *Record of Individual Inactive Duty Training:* must have all three signatures.

c. UTAPs report.

d. When submitting Line of Duty (LOD) determinations for processing in the Electronic Case Tracking System (ECT), certified orders are not the

only source document available to substantiate a member's duty status. A completed certified order, paid travel voucher, Points Credit Summary Report from vMPF, or Leave and Earning Statement are all valid forms of verification. In the absence of any of these documents, a memorandum from the unit commander confirming personal knowledge of the member being in status during the time of the incident will also be accepted.

iii. SF 600 entry by a privileged military medical provider to document the Admin LOD. The following will be included:

a. Date of injury/illness

b. Status (UTA, AT, RPA orders, etc.)

c. Diagnosis

d. LOD Finding

e. Provider's signature and date

F. When LODs are not required. A LOD must be supported with clinical documentation and source information as required IAW DAFI 36-2910 and DoDI 1241.01.

i. When more than 180 days has passed since release from the period of service and member has not reported the condition.

a. DODI 1241.01 does allow for "special circumstances" by which a LOD may be initiated after 180 days. Exceptions to the 180-day rule is for latent onset conditions that have had delayed diagnosis.

b. If member was aware of condition and failed to report or seek treatment the exception may not apply. Failure to timely report may be considered misconduct.

c. RMUs should contact AFRC/SGO for guidance in instances when this may apply BEFORE initiating the LOD.

ii. Prior Service Conditions (PSC). LODs are not required for medical issues incurred while part of any other branch of service, these conditions will be well documented in the Service Treatment Record (STR) and should be documented in the Separation History Physical Exam (SHPE) for which member can file claims with VA. Upon separation from active duty and joining the Reserves, members are presumed 'fit for duty.' Prior service conditions that worsen to the point of 'potential unfitness' while 'not in status' do not require an informal LOD. In these instances, for unfitting conditions an IRILO will be required. If during the IRILO phase the member is deemed medically disqualified and deferred for full

processing and submission to the Physical Evaluation Board (PEB), AFRC/SGO will initiate a PSC determination and provide the result (from AFRC/A1) of such back with the I-RILO case adjudication. This will result in either referral to the MEB/IDES process (PSC - Yes) or referral into the Non-duty related fitness for duty process, aka the NDDES (PSC-No) (See Chapter 39).

a. RMUs may request Prior Service Condition review in advance of IRILO/LOD case processing by emailing copies of medical documentation from prior period of service along with member's DD214 to AFRC.SGO.PhysicalStandards@us.af.mil with subject line "Last Name, First Name, Prior Service Condition Determination."

iii. Service Aggravation and 8 Year Rule. Prior service conditions that are potentially aggravated while performing a period of duty as an AFR member or for which the 8 Year Rule may apply **WILL** require an Informal LOD. In these instances, the LOD outcome will dictate, for potentially unfitting conditions, whether a MEB/IDES or NDDES case is required.

Note: *If the RMU is unsure whether a LOD should be completed, then they will email the AFRC/SGO organization email box* AFRC.SGO.PhysicalStandards@us.af.mil *for clarification on case processing.*

G. Informal LOD. When administrative processing is not appropriate, an Informal LOD determination is initiated on an AF Form 348. Items required to complete an Informal LOD in ECT are as follows:

i. Initial Clinical documentation and other supporting medical documentation.

a. To alleviate wait times and incomplete documentation, the member will complete a DD Form 2870, Release of Information form. (Period of treatment: From the date condition/treatment started to an end date that will cover all treatment rendered, through the current date or "Until Revoked".)

b. Use AHLTA, MHS Genesis JLV, ASIMS, composite Service Treatment Record (STR), and any other available electronic health record.

ii. PCARS "GRBOTH"

a. PCARS can most easily be procured from your servicing MPF or by unit CSS with access to MilPDS. AFRC/A1KK has advised the servicing FSS to supply these to RMUs and CCs upon request for LODs processing purposes. The AFRC/SG3P LOD program folder on KX has helpful instructions for pulling PCARS from MILPDS.

b. vMPF PCARS will no longer be accepted per AFRC/A1KK. PCARS from MilPDS labeled "RSGRBTH" (Please refer to the Help tab in ECT for PowerPoint instructions)

iii. Status verification document(s), at least one of the following:

a. Certified orders: Must be certified by filling in block 36-44 of the AF Form 938. (For Deployments: CED orders, NATO, etc. with the AF Form 938.)

b. AF Form 40A, *Record of Individual Inactive Duty Training:* must have all three signatures.

c. UTAPs report.

d. When submitting Line of Duty (LOD) determinations for processing in the Electronic Case Tracking System (ECT), certified orders are not the only source document available to substantiate a member's duty status. A completed certified order, paid travel voucher, Points Credit Summary Report from vMPF, or Leave and Earning Statement are all valid forms of verification. In the absence of any of these documents, a memorandum from the unit commander confirming personal knowledge of the member being in status during the time of the incident will also be accepted.

iv. If involving a Motor Vehicle Accident (MVA), then:

a. Police report (if applicable)

b. Map showing the location of the incident in relation to the duty station and home of record or airport terminal.

v. If involving a Death: death certificate or autopsy report (if applicable)

vi. AF Form 978, Mishap Report. When applicable based on the mechanism of injury or incident causing the injury, the Unit Safety Rep (USR) should have the member complete the AF Form 978. Signatures from member, USR and Commander are required and should be file with Wing Safety office as well.

a. If not complete, the unit CC should provide a MFR explaining why an AF Form 978 was not accomplished to the approving authority, under LOD Reform initiative this is the Wing/CC.

b. While the Mishap Reports is a valuable tool in determining the facts of a case and at times whether a Formal LOD versus Informal is required, the Wing/CC will determine if mandatory or not. For any LOD submitted to

the LOD Board (Formal) for which the condition requires a Mishap report, the completed form is required.

vii. Member Statement. This can be an MFR (must have date and signature) or via official email (from a @mail.mil or @us.af.mil account). A standardized product secondary to LOD Reform initiative for member statement is forthcoming and will be posted to the AFRC/SG3P LOD program folder on KX.

viii. Medical Line of Duty Briefing memo. This is available on the AFRC/SG3P LOD program folder on KX.

H. Medical Officer. A privileged military medical provider will review the member's case and provide medical opinion that will address the following:

i. EPTS, onset (etiology), and a medically based opinion regarding Service Aggravation (whether for or against SA).

ii. Distinction between symptoms and condition onset is crucial.

a. LOD is based on the onset of the conditions, **NOT** the manifestation of symptoms or when the condition was diagnosed.

iii. Distinguish between the acute injury and the chronic condition.

Note: ***DO NOT*** *use the medical opinion section of the LOD to address fitness for duty, qualifications for special operations duty or the care/treatment plan. The medical opinion section of a LOD should focus on the medical facts and opinions related to EPTS, etiology, and service aggravation necessary to adjudicate the LOD.* ***For example:*** *The medical opinion provided for an acute Myocardial Infarction would be dramatically different from the medical opinion given for the underlying Cardiovascular Disease.* ***DO NOT*** *use Medical Officer Section to address fitness for duty or care,* ***ONLY*** *address EPTS, Etiology, etc.*

I. LOD Process Roles. The following list outlines the queue each LOD may process through.

i. Unit Commander. Validates status and assures no misconduct by the member.

a. Unless a medic, the Unit CC does not have a medical opinion.

ii. Wing Judge Advocate. Ensures legal sufficiency only. Optional Step at discretion of the Wing/CC as of 3 Sept 21 issuance of DAFI 36-2910.

iii. Wing Commander. Approving Authority for all Informal LODs with the exception of restricted sexual assault or NILOD findings for which the 8-year rule may apply. Serves as the Appointing Authority for situations requiring a Formal LOD.

J. AFRC/LOD Board. The following roles outline responsibilities at the Board level.

i. Medical Technician (SGO). The medical tech review consists of: Review of cases**,** RFA actions, and Forwards LOD to the Board medical officer.

ii. AFRC Medical Officer (SGO). Reviews cases as specified in DAFI 36-2910.

iii. AFRC Judge Advocate (JA). Reviews cases as specified in DAFI 36-2910.

iv. AFRC/A1. The final Approving Authority for restricted sexual assault, 8-year rule cases and Formal LODs.

K. Line of Duty Determination. Once a determination has been made it will generate an AF Form 348. This determines eligibility for any of the benefits noted previously.

L. Possible Line of Duty Determinations (LODDs).

i. In Line of Duty (ILOD)

a. For ARC members, this includes while the member was in any duty status (including direct travel status).

b. Service Aggravation. A condition is aggravated by military service when there is a worsening of a pre-service (period of service) medical condition, over and above natural progression, caused by trauma or the nature of military service.

ii. Not in Line of Duty (NILOD)-Not Due to Member's Misconduct.

a. Absent Without Authority.

b. Existed Prior to Service (EPTS)-Not Service Aggravated (NSA).

iii. NILOD-Due to Member's Misconduct.

M. Service Aggravation. DODI 1241.01 and DAFI 36-2910 definition of Service Aggravation is "worsening of a pre-service medical condition, over and above natural progression, caused by trauma or the nature of military service. Natural progression is the course an illness, injury or disease would take over time, regardless of military service." Simply getting worse while in status or an acute flare up of a pre-existing condition IS NOT service aggravation.

N. Appeal of the Final LOD Determination. If a member does not agree with the findings of an Informal LOD the following process can be accomplished.

i. Request in writing by the member within 30 days to the Wing/CC through the MPF.

ii. SM may provide significant/new information, though it is not required.
iii. Appointing Authority (Wing/CC) can approve and send to AFRC/LOD Board for review.

O. Access to care under LOD. Refer to AFMAN 41-210 for specific guidance on access to care entitlements for Reserve members.

P. Formal LODs (AF Form 261). FLODs involve an investigation and are required for all misconduct/AWOL. All Formals start as Informal LOD, at the Wing/CC step an investigating officer is appointed.

Q. Reinvestigation of the Formal LOD Determination. A Formal LOD determination may be opened for Reinvestigation only if new and significant evidence indicates likelihood of error. The member's statement alone or disagreement with the determination does not constitute new evidence. The Reinvestigation is limited to addressing only those issues raised by new evidence.

i. See AFI 36-2910 for specifics on Reinvestigation.

R. Common Errors and Return for Action (RFA) Reasons.

i. LODs are processed for diagnosis only. Do not use symptoms as a diagnosis (e.g., pain or lumbago). If the only ICD-10 code provided at the start of the LOD is for symptoms, it will be corrected by the RMU with the actual diagnosis before the close out of the LOD when possible or a new LOD will be started to reflect the definitive diagnosis.

ii. Multiple diagnoses (only applicable to MVAs or injuries that stemmed from one direct incident).

iii. Date of initial treatment does not match with supporting medical documentation.

iv. Lack of supporting documents (e.g., radiology results), follow up treatment, initial ER admission, incorrect PCARS service history, IO report for Formals, Police reports for MVAs and map where incident occurred.

v. Military status not covering the dates of injury.

vi. AF Form 938 not certified completing the duty.

vii. Medical Officer digital signature on AFRC IMT 348.

viii. Poorly written or supported case.

S. End of LOD Care at DOD Facility. There is an end to care and treatment under a LOD at DOD facilities. Refer to DODI 1241.01 and AFMAN 41-210, the RCSM's medical condition has been determined to be ILOD.

T. Cancelling LOD. Only the local Medical Officer can cancel a LOD. Once a LOD has been initiated, the member may not choose to cancel. The LOD protects both the government and the member, so due process should occur. If there is a need cancel a LOD due to member lack of providing required records (medical, administrative, or proof of status), necessary to support/validate claim, the provider will make and entry in the STR outlining required records not provided and attempts made to procure such, in addition to the explanation for canceling the case required when doing so in the automated LOD system. Also, the records required for a LOD may also be necessary as part of a duty limiting condition or fitness for duty decision as well. In these instances, the RMU will follow procedures in this TIG for providing member a suspense, and notification/deferral to commander for administrative actions, reference chapter 7.

U. LOD vs 8 Year Rule vs Prior Service Condition. Correctly identifying the need for a LOD versus PSC, or PSC versus a LOD, by the initiating entity (RMU), is of vital importance to potential benefits/entitlements and if needed fitness for duty and disability evaluation system (DES) processing. The 8-year rule applicability and limits also need to be fully understood by all Wing level LOD adjudicators to be effectively communicated to the customer (service member).

i. The LOD Process, in most instances specifically the informal LOD process; is required when a condition is identified or potentially linked to a period of duty as an Air Force Reserve member. LOD process does not mean it will finalize as "in the line of duty (ILOD)", but the process does have to occur. The starting point/presumption is ILOD and the LOD process will either 1) validate/finalize an ILOD outcome or, 2) the necessary evidence and standard of proof is met to finalize the process as 'Not in line of Duty' (NILOD). Process being required and outcome are not the same.

ii. 8 Year Rule, Can only be adjudicated/documented via the Informal LOD process on the AF Form 348 by AFRC/A1. 8 Year Rule is not a LOD finding, but instead a secondary entitlement under disability law, that specifically applies to NILOD outcomes, yet permits entrance of member into the compensable DES process in spite of a NILOD outcome. There are 4 prerequisites for the 8-year rule to be applied 1) Disqualifying/unfitting condition, 2) Member has 8 years of TAFMS, 3) Was in AFR status for 30 days or more at time condition became unfitting and was not released from that status early, and 4) the LOD process as adjudicated by the Approving Authority found NILOD by reason of EPTS –Not Service Aggravated. The Wing/CC findings is NILOD, which is the LOD finding. However, the informal LOD will route to the LOD Board and AFRC/A1 who will document the 348 that the 8 year applies, and member is eligible for MEB/IDES processing. MEDCON/INCAP would not be accessible due to NILOD finding

though. Again the 8-year rule is not a LOD finding itself, but a determination of eligibility for MEB/IDES processing in spite of the NILOD outcome from the Wing/CC.

iii. Prior Service Condition, Similar to the 8-year rule in that it is a process by which connection to service not associated with AFR may be documented and provide eligibility for entrance into the MEB/IDES pathway. Different from 8-year rule in that member was not in any AFR status at time it worsened or presented as disqualifying/unfitting. In fact, this is specifically for conditions originating from another Service/Component that has worsened to the point of unfitness **while not in status**.

Chapter 10
DAFI 40-301, *Family Advocacy Program*

1. References / Further Reading.

A. AFMAN 41-210, *Tricare Operations and Patient Administration Functions*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This instruction applies to active component installations (excluding the Air Reserve Component which includes Air Force Reserves and Air National Guard unless these members are activated on title 10 or title 32 orders and have military medical benefits.). It additionally specifies urgent response, safety planning and care coordination for individuals who are not eligible for military medical care yet may be involved in alleged maltreatment involving any DOD personnel.

4. Guidance.

A. Services Available to Service Members. RMUs will detail strategy (MOU/MOA/Support Agreement) for members accessing Domestic Violence (DV) resources; community or through MTFs.

B. See DAFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this DAFI currently.

Chapter 11
AFMAN 41-209, *Medical Logistics Support*

1. References / Further Reading.

A. AFPD 41-2, *Medical Support*

B. AFI 23-111, *Management of Government Property in Possession of the Air Force*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. Medical Logistics provides equipment, materiel, services, and information to the Air Force (AF) medical mission. This applies to all Air Force, Air Force Reserve and Air National Guard (ANG) activities with an assigned Medical Supply (FM) account as defined by AFI 23-111, Management of Government Property in Possession of the Air Force. It does not apply to non-FM account supported medical units unless stated otherwise.

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFMAN currently.

Chapter 12
AFI 44-102, *Medical Care Management*

1. References / Further Reading.

A. AFI 90-6001, *Sexual Assault Prevention and Response (SAPR) Program*

2. Self-Assessment Communicators.

A. 44-102, *Medical Care Management* (**Not** 1102 protected [Ground RMU ART and/or his/her designee runs communicator])

B. 44-102, *Medical Care Management* (1102) (**1102 protected** [Ground RMU ART and/or his/her designee runs communicator])

C. 44-102, *Medication Management* (**Not** 1102 protected [Ground RMU ART and/or his/her designee runs communicator])

3. Introduction.

4. Guidance.

A. Medical Response for Sexual Assault Victims. Each MTF is required to have a written plan describing the medical response for sexual assault victims. While RMUs are not treatment facilities the requirement must still be met. Depending on whether a RMU is collocated with a host ADMTF or non-collocated how this requirement is met will differ. Reserve Medial Units (RMU) do not treat. This plan must state how a sexual assault victim would be treated if an acute sexual assault is reported to the RMU. Along with notifying the SARC of the assault, the RMU needs to know where to send the victim to receive a Sexual Assault Forensic Exam (SAFE). AFI 44-102, Medical Care Management is written for an MTF to comply with. The plan needs to reflect how RMU staff would respond.

i. **Collocated AFR Wings –** Ensure a copy of the host MTF medical response is procured and kept on hand, is part of clinic orientation and that all RMU staff are aware of the plan and its contents. Coordinate with the installation SARC and host ADMTF to ensure provisions for UTA weekends are accounted for in the response plan. The plan should cover all items in AFI 44-102 but is primarily the responsibility of the host ADMTF and SARC with RMU coordination and consideration. There is no need for the RMU to draft their own plan, but it is important that they ensure that the ADMTF incorporates the Reserve tenants in their plan.

ii. **Non-Collocated AFR Wings.** The RMU will have to work with the SARC to draft a plan, a lot of the work may already be done if the SARC has MOU/MOAs in place. The plan coordinated with the Installation

SARC will meets all the requirements outlined in AFI 44-102. Additional information can be located at: https://kx.health.mil/kj/kx7/AFRCAerospaceMed/Pages/home.aspx

iii. **Director of Psychological Health.** The DPH can function as a liaison in establishing the plan, to include the Family Advocacy Program.

Chapter 13
AFI 44-108, *Infection Prevention and Control Program*

1. References / Further Reading.

A. AFI 48-145, *Occupational and Environmental Health Program*

B. AFI 48-137, *Respiratory Protection Program*

C. AFI 10-250, *Individual Medical Readiness*

2. Self-Assessment Communicators.

A. AFI 44-108 Infection Prevention AES, ARC, and ANG

3. Introduction. This AFI describes procedures for preventing and controlling healthcare-associated infections (HAIs) in patients, visitors, volunteers and staff (military, civilian, and contract personnel) within any healthcare setting such as military treatment facilities (MTFs), Limited Scope Military Treatment Facilities (LSMTFs), Aeromedical Evacuation Squadrons (AESs), Air Reserve Component (ARC) Medical Units (comprised of Air Force Reserve Medical Units [RMUs] and Air National Guard Medical Units [GMUs]) and Dental Clinics.

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 14
AFI 44-119, *Medical Quality Operations*

1. References / Further Reading.

A. AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted)*

B. AFMAN 41-209, *Medical Logistics Support*

C. AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment Program*

D. AFMAN 47-101, *Managing Air Force Dental Services*

2. Self-Assessment Communicators.

A. DHA-PM 6025.13 Vol 4 & AFI 44-119 Credentials Management (AFRC Sup)

3. Introduction. Outlines military treatment facility (MTF) roles and responsibilities in clinical performance improvement (PI), explains patient safety and risk management (RM) programs, PI/accreditation/self-inspection requirements, credentials and privileging processes, and scope of practice to provide optimal healthcare delivery. This instruction applies to all Air Force Medical Service (AFMS) personnel and where specifically identified within this instruction for units of the Air Reserve Components (ARC) and Aeromedical Evacuation (AES).

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 15
AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

B. AFMAN 36-2136, *Reserve Personnel Participation*

C. AFMAN 41-210, *Tricare Operations and Patient Administrative Functions*

D. DAFMAN 48-123, *Medical Examinations and Standards*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This instruction provides guidance for the identification, treatment, and management of personnel with substance use disorders (SUDs) and describes AF policy regarding alcohol abuse, prescription drug misuse, and drug abuse. This instruction applies to all active duty (AD) USAF members, and to members of the USAF Reserve Command (AFRC) and Air National Guard (ANG) whenever eligible for DOD medical services, except for paragraph 3.2, which always applies to all Reservists. The AFRC and ANG do not have separate systems to provide behavioral health treatment, including SUD treatment.

5. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently. All RMUs should be familiar with the following two references as they are often questions of the Commanders.

A. 1.9.18. The ADAPT Program Manager collaborates and communicates with Reserve Medical Unit and Guard Medical Unit personnel, and Air Reserve Component Commanders, when required by Air Force and Department of Defense policy, regarding any Air Force Reserve Command or Air National Guard member who presents to the Alcohol and Drug Abuse Prevention and Treatment Program for services.

B. 1.9.19. Provides fitness for duty or status recommendations to Air Reserve Component Commanders for Air Reserve Component members who have been referred by the Alcohol and Drug Abuse Prevention and Treatment Program Manager and seen by non-military providers for substance use disorder evaluation and/or treatment. (T-1)

C. 1.13.1. in accordance with DAFMAN 48-123, *Medical Examinations and Standards*, and AFMAN 36-2136, *Reserve Personnel Participation* (Paragraph 1.6.), unit Commanders are encouraged to place the member suspected of having a substance use disorder on orders to receive the initial assessment and treatment recommendation from the Alcohol and Drug Abuse Prevention and Treatment Program (evaluation only).

Chapter 16
AFI 44-153, *Disaster Mental Health Response & Combat and Operation Stress*

1. References / Further Reading.

A. 10-403, *Deployment Planning and Execution*

B. 44-172, *Mental Health*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This AFI establishes the requirement and guidance for Disaster Mental Health Response (DMHR) teams at all active-duty Air Force (AF) installations, integrating resources and efforts of the Air Force Reserve (AFR) and Air National Guard (ANG).

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 17
AFI 44-172, *Mental Health*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

B. AFI 10-403, *Deployment Planning and Execution*

C. DAFI 40-301, *Family Advocacy*

D. AFMAN 41-210, *TRICARE Operations and Patient Administration Functions*

E. AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*

F. AFI 44-153, *Disaster Mental Health Response & Combat and Operational Stress Control*

G. DAFMAN 48-123, *Medical Examinations and Standards*

H. AFI 90-5001, *Integrated Resilience*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This instruction applies to all active component Air Force (AF) members and members of the Air National Guard (ANG) when activated under Title 10 active duty in the Air National Guard of the United States (ANGUS) status and Air Force Reserve (AFR) IMAs and unit-based personnel that are on Title 10 active-duty orders for even one or two days and functioning within a DoD medical facility (or equivalent). However, given the mission/nature of weekend trainings for unit-based personnel (i.e., UTAs) and the limited privileges, it does not apply to such individuals during unit drill weekends when not on active-duty orders. Our Airmen are in Title 10 status during those weekends, IAW AFMAN 41-210, TRICARE Operations and Patient Administration Functions, Section 2B. The AFR does not have a separate system to provide mental health treatment. Clarification about AFR-specific policies, processes, and/or procedures should be directed to HQ AFRC/SG's MH Consultant. This guide will provide important SG elements regarding medical qualifications for participation, compliance with medical requirements/standards and all RMUs should familiarize themselves with this content.

4. Guidance.

A. Commander Directed Mental Health Evaluations. CDE must be conducted IAW DODD 6490.1, Mental Health Evaluations of Members of the Armed Forces and DoDI 6490.04, Requirements for Mental Health Evaluations of Members of the Armed Forces). The procedures for this evaluation process are intended to protect the rights of the individual (REF: Public Laws 101-510 and 102-484 and maintain good order and discipline and minimize improper CDE referrals (see DODD 7050.6; Military

Whistleblower Protection). The consequences for noncompliance with CDE are possible administrative or UCMJ action.

i. HQ AFRC/SGO may require a MMHE as part of an occupational, worldwide duty/deployment evaluation or disability evaluation system processing, see Chapter 24. This should not be confused with and IS NOT the same as a CDE. The CDE will be focused on treatment recommendations, advising the commander how leadership can assist in the treatment plan, duty limitations, need for DES referral or administrative separation for personality disorders for unsuitable conditions that are not subject to DES. The MMHE would come later after it has been determined the condition is both unfitting for service (versus unsuitable), and treatment has been unable to resolve the member status to such they are deployable and/or meet retention standards.

Chapter 18
AFI 44-178, *Human Immunodeficiency Virus Program*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

B. AFI-41-210, *Tricare Operations and Patient Administration Functions*

C. AFI 44-108, *Infection Control Program*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. Air Force Reserve Command utilize this instruction along with supplements to provide specific guidelines for the administration of Air Reserve Component (ARC) personnel infected with HIV.

4. Guidance. HIV is medically disqualifying, whether symptomatic or not requires an IRILO.

A. Human Immunodeficiency Virus (HIV) seropositive, confirmed. All Air Force Reserve personnel will be tested for the presence of the HIV antibody IAW AFI 44-178, Human Immunodeficiency Virus Program. IAW AFI 44-178, confirm repeat positive enzyme immunoassay by Western Blot.

i. A Positive HIV Test result. By itself a positive result is not medically disqualifying until confirmation of results is complete. Once a member is verified to have HIV seropositive, they are disqualified and placed on an AAC 37 utilizing the AF Form 469.

ii. When Non-Duty Disability Evaluation System (NDDES) Evaluation Is Required. Reserve members testing positive for the HIV antibody must have a Non-Duty Disability Evaluation System (NDDES) evaluation after their immediate Commander determines they may be utilized in the selected Reserve. The immediate Commander should communicate the decision that the service member can be utilized by completing a MFR for inclusion in the medical record. The evaluation will follow the San Antonio Military Medical Center (SAMMC) Standard Clinical Protocol listed in AFI 44-178. If the Commander indicates the member cannot be utilized a Non-Duty Disability Evaluation System (NDDES) case will not be accomplished and the Commander and FSS will proceed with administrative separation. For not-ILOD cases the RMU may complete an IRILO first or go directly to the full Non-Duty Disability Evaluation System (NDDES) case at discretion of the AMRO.

iii. SAMMC. If AGR, the evaluation must be completed within three months of the decision to retain the member. The RMU will provide the member with a copy of

the SAMMC Standard Clinical Protocol to provide to their private physician. RCSMS on long tour orders or AGR tours may go directly to SAMMC.

iv. **Return to Duty.** Reserve members who test positive for the HIV antibody and have been returned to duty by AFRC/SGO will be evaluated annually and their case forwarded to AFRC/SGO for appropriate review and action. The annual evaluation will consist of reporting the SAMMC Standard Clinical Protocol to include a CD-4 count, medications being taken, presence of lymphadenopathy, and energy status. The CD-4 count must be accomplished at least every six months. This annual evaluation is also at the member's own expense.

B. Air Force HIV Testing Procedures. Adequate management of the HIV program and infected AFR personnel require the Competent Medical Authority to read, understand, and apply AFI 44-178.

i. **Reserve Medical Unit Commander (RMU/CC).** The RMU/CC is responsible for the HIV testing program and appoints an HIV designated physician and one or more alternates if desired.

ii. **ARC personnel.** Service Members (SM) are screened for serological evidence of HIV infection every two years, preferably during their Preventive Health Assessment.

iii. **Lab Results.** Per AFI 44-178, the Epidemiology Lab (USAFSAM/PHE) is required to send HIV positive notifications to the requesting RMU/CC, either through FedEx priority overnight shipping or preferably encrypted e- mail since it is less expensive and more efficient. However, because no RMU/CC is available during the week for AFR units, the notification package for an AFR member with a positive HIV test will instead be sent to the Senior Air Reserve Technician (Sr. ART) at the ground RMU. The Sr. ART is responsible for sharing the notification package with the RMU/CC.

iv. **RMU Sr. ART.** Telephone contact will be initiated with the Sr. ART by Epidemiology Lab personnel followed by a test e-mail to ensure encryption capabilities. Following receipt of the test e-mail response, results and instructional memorandums, one addressed to the ground RMU Sr. ART, and one addressed to the ground RMU Commander, along with two AF Form 74s, will be transmitted. Both AF Form 74s are required to be filled out, signed, and returned through e-mail, so that the Epidemiology Laboratory confirms that the patient has been made aware of the results. Following receipt of both AF Form 74s, the Epidemiology lab personnel will enter and certify the results in CHCS.

v. **RMU/CC Notification.** Upon receiving the HIV positive test results, the RMU Sr. ART will immediately notify RMU/CC.

vi. **Wing/Unit CC Notification.** The RMU/CC reviews the reports and immediately notifies the wing/unit Commanders of the positive HIV test results.

vii. **RMU Designated Provider.** The RMU Sr. ART or RMU/CC will either notify the RMU's HIV designated provider, a physician at HQ AFRC/SGO, or a host Active-Duty Military Treatment Facility's HIV designated provider to properly notify and counsel individuals with serologic evidence of HIV infection. Copies of the positive results will be given to physician designated to give advice and counsel the individual. Member notification will occur immediately after the Wing/Unit Commanders are notified and will not be delayed until the individual's Unit Training Assembly (UTA). If a RMU HIV designated provider makes the notification, they must be in a military status at the time of making the notification. The designated physician will also ensure spouses and contacts of HIV infected reserve personnel are notified appropriately.

viii. **Information/Counsel to Member.** Individuals will be:

a. Advised on the significance of the test results, mode of transmission, the appropriate precautions and personal hygiene measures required to minimize transmission through sexual activities and/or intimate contact with blood or blood products, and of the need to advise any past or future sexual partners of their infection.

b. Women shall be advised of the risk of perinatal transmission during past, current, and future pregnancies.

c. The individuals shall be informed that they are ineligible to donate blood, sperm, organs, or tissues and shall be placed on a permanent donor deferral list.

d. Directed to immediately notify their spouse, if applicable, of their positive HIV status and have the spouse contact the notifying physician directly.

e. Informed that their local Civilian Public Health (PH) Authority, IAW state law, will be notified of their HIV positive status and the PH Authority will be contacting the individual to arrange counseling and a confidential patient epidemiologic interview.

f. The individual will provide a telephone number where they can be reached and will remain accessible for further communication.

g. Advised that they will be referred for a medical evaluation of fitness for continued service in the same manner as service members with other chronic or progressive illnesses IAW DoDI 1332.18.

h. AFR members whose condition is determined to meet Line of Duty requirements may have initial and/or annual HIV evaluations performed at regional military facilities. AFR members not meeting Line of Duty requirements will have an initial evaluation by a civilian HIV specialist following the standard clinical protocol outlined in Attachment 11 to AFI 44-178.

i. **Unit CC Responsibility.** The member's unit Commander will arrange to issue the "Order to Follow Preventive Medicine Requirements" to the member at the member's next UTA. Guidelines for administering the order are found in AFI 44-178. The order is AFI 44-178. When the order is given, a privileged military provider must be present to answer any medical concerns of the member. The Unit CC will formally decide to retain the member in selective service via a MFR and submit a copy to the RMU and give a copy to the member.

ii. **Civilian PH Authority.** The RMU Sr. ART will confirm the Civilian PH Authority completed the patient epidemiologic interview and assure members retained in the Selected Reserve are medically evaluated annually and accomplish a CD-4 count at least every six months for the purpose of determining status for continued military service.

iii. **Medical Record Coding HIV -1 Infection.** Follow current ICD CM coding guidelines for medical record coding of HIV infections. Currently, results will be recorded using the following V-codes:

a. V72.60 - Negative results

b. V72.62 - Positive results

Chapter 19
AFMAN 47-101, *Managing Air Force Dental Services*

1. References / Further Reading.

A. AFMAN 41-210, *TRICARE Operations and Patient Administration Functions,* Ch. 6

B. DoDI 6025.19, *Individual Medical Readiness*

2. Self-Assessment Communicators.

A. 47-101**,** *Management of Air Force Dental Services* (Ground RMU with AOME UTC mission)

3. Introduction. This instruction provides guidance and instructions for the Air Force Dental Services and implements AFPD 47-1, Dental Services. It also implements the following directives and instructions for the Dental Service and its activities worldwide: Title 10, USC, Sections 1074, 1074a, 1076, 1076a, and 1077; DOD/HA Policy 98-031 Revised Utilization Management Policy for the Direct Care System when applied to Dental Practice. It also provides guidance to meet the civilian standards of the Occupational Safety and Health Administration, the Centers for Disease Control and Prevention, and the American Dental Association.

4. Guidance. See AFMAN and Air Force Dental Service KX for further guidance. AFRC/SG3P has no further policy/guidance regarding this AFI currently.

A. COVID 19 Pandemic response waiver of every three military dental exams. During the COVID-19 Pandemic response a waiver has been issued for the required every three-year military exam allowing substitution with a civilian exam documented on the DD Form 2813 in certain instances. Current waiver is available HERE. This waiver does not apply across the board to all locations/RMUs, at all times, and is only applicable to locations unable to maintain normal operations due to local situation. RMUs seeking to utilize this waiver must file a Deviation from Normal Operations memo with AFRC/SG3P (afrc.sgp@us.af.mil).

Chapter 20
AFI 48-101, *Aerospace Operational Medicine*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

B. AFI 10-250, *Individual Medical Readiness*

C. AFI 10-403, *Deployment Planning and Execution*

D. AFMAN 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Badges*

E. AFI 48-104, *Tobacco Use in the Air Force*

F. AFI 48-170, *Preventive Health Assessment*

G. AFMAN 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*

H. AFI 48-116, *Food Safety Program*

I. AFI 48-117, *Public Facility Sanitation*

J. DAFI 48-122, *Deployment Health*

K. DAFMAN 48-123, *Medical Examinations and Standards*

L. AFI 48-144, *Drinking Water Surveillance Program*

M. AFI 48-145, *Occupational and Environmental Health Program*

N. AFMAN 48-149, *Flight and Operational Medicine Program*

2. Self-Assessment Communicators.

A. 48-101 Aerospace Operational Medicine (Tracked by RMU with AOM mission)

i. RMUs should attach the most recent EMC and AMC minutes (with reports from subordinate orgs) each time they assess this SAC. Comprehensive minutes from AMC and evidence of receipt of reports/minutes from lower working groups (AMRO, FMWG, OEHWG) and elevation to EMC in many ways answers most of the questions in the SAC and could thus substitute detailed question-by-question assessment by simply referring to attached minutes, as long as they are current.

ii. SG3P has provided line by line guidance on this SAC and will maintained in the KX Flight and Operational Medicine Folder.

3. Introduction. This instruction addresses the requirement for development of Team Aerospace. This publication applies to the regular Air Force and the Air Reserve Components. It provides guidance and establishes procedures for conducting the multidisciplinary aspects of the Aerospace Operational Medicine (AOM). It describes key AOM programs in support of the operational aerospace mission and links them to the desired operational effects: Promote and Sustain a Healthy and Fit Force, Prevent Illness and Injury, Restore Health, and Sustain Human Performance.

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 21
AFI 48-102, *Medical Entomology Program*

1. References / Further Reading.

A. AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*

2. Self-Assessment Communicators.

A. 48-102, *Medical Entomology (Standalone)*

3. Introduction. This AFI assigns responsibilities for the prevention of vector-borne diseases and management of medically important pests through the application of Integrated Pest Management (IPM) practices.

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 22
AFI 48-104, *Tobacco Free Living*

1. References / Further Reading.

A. AFPD 40-1, *Health Promotion*

B. AFI 91-203, *Air Force Consolidated Occupational Safety Instruction*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. Tobacco use is the leading cause of preventable death in the United States. Tobacco use degrades Air Force readiness, health, and leads to preventable health care costs. The Air Force discourages the use of all tobacco products. Tobacco includes all products that may be configured to deliver nicotine, including but not limited to, cigars; cigarettes; electronic cigarettes (e-cigarettes); stem pipes; water pipes; hookahs; vaporizers; smokeless products that are chewed, dipped, sniffed, or "vaped"; and any other nicotine delivery system that the Food and Drug Administration (FDA) defines as a tobacco product.

Note: *The definition of tobacco does not include FDA-approved prescription or over-the-counter nicotine replacement therapy.*

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 23
AFMAN 48-105, *Public Health Surveillance*

1. References / Further Reading.

A. AFI 48-101, *Aerospace Medicine Enterprise*

B. AFI 44-102, *Medical Care Management*

C. AFI 44-108, *Infection Prevention and Control Program*

D. AFI 48-102, *Medical Entomology Program*

E. AFI 48-116, *Food Safety Program*

2. Self-Assessment Communicators.

A. AFMAN 48-105, *Public Health Surveillanc*e

B. 48-105 (1102), *Public Health Surveillanc*e (1102)

3. Introduction. This AFI explains the procedures for surveillance, prevention, and control of diseases and conditions of public health or military significance. This instruction applies to all active duty (AD) Airmen, Air National Guard (ANG) members, and AF Reserve (AFR)

Note: *ANG and AFR will be collectively referred to as Air Reserve Component (ARC) within an Air Force (AF) military treatment facility (MTF) or similar unit responsible for public health activities.*

4. Guidance.

A. Latent Tuberculosis Infection (LTBI) procedures. Member is place on a Deployable with Limitation (DW) code on an AF Form 469.

i. Determine if member had been deployed to a high-risk area by conducting a public health interview.

ii. If it is determined that a member has been deployed to a high-risk area an LOD will be initiated, and member sent to active duty treatment facility.

iii. If member is under treatment for Latent TB infection (LTBI), continue DW code for the duration of treatment, though a permanent change to P2 on the PULHES may be warranted on the AF Form 422. Additionally, AF Form 469 will need to contain the following language "Medication usage requiring close clinical follow-up, member may need waiver prior to deploying check gaining COCOM for further guidance/information."

Note: *Rationale is that those on therapy for LTBI require monthly follow-up for assessment of signs of hepatitis, adherence to medication regimen, and surveillance for symptoms of adverse drug reactions or interactions. Patient's being treated for LTBI who experience possible adverse effects need to be advised to stop the medication and consult a healthcare provider immediately. Additionally, laboratory testing may be necessary depending on co-morbid conditions (liver disease, history of liver disease, regular use of alcohol, risks for chronic liver disease, HIV infection or pregnancy [shouldn't deploy anyway]). Baseline and monthly testing is based on individual risk especially if taking multiple medications besides the LTBI treatment. During treatment anytime there are symptoms of hepatitis, LFTs are recommended for patient. For these reasons, some locations may not be able to support following a member, but formal AAC 31 is likely not needed. The thirty days is to allow for at least one clinical follow-up prior to TDY.*

B. Active Tuberculosis Infection procedures. If TB is in active stage, member is placed on an AAC 37 on the AF Form 469 until completion of treatment and I-RILO/NDDES/MEB processing.

i. If member has not been deployed - send to private physician.

ii. If member has active TB, place on AAC 37 until treatment is completed and member is determined to be inactive and processed through the IRILO, NDDES, or MEB process.

Chapter 24
DAFMAN 48-108, *Physical Evaluation Board Liaison Officer (PEBLO) Functions: Pre-Disability Evaluation System (DES) and Medical Evaluation Board (MEB) Processing*

1. References / Further Reading.

A. DoDI 1332.18, *Disability Evaluation System (DES)*

B. DoDI 6130.03, *Volume 2, Medical Standards for Military Service: Retention*

C. AFPD 48-1, *Aerospace & Operational Medicine Enterprise (AOME)*

D. DAFMAN 48-123, *Medical Examinations and Standards*

E. AFI 48-101, *Aerospace Medicine Enterprise*

F. DAFI 48-122, *Deployment Health*

G. DAFI 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay*

H. AFI 48-133, *Duty Limiting Conditions*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This chapter explains AFRC/SGO requirements for Air Force Policy Directive, 48-1, Aerospace and Operational Medicine Enterprise (AOME). It identifies and defines the requirements, policies, procedures, activities, and minimum expectations necessary to ensure a successful IRILO, NDDES, and MEB process.

4. Guidance.

A. Initial RILO Required Documentation. Per DAFMAN 48-108, Initial RILO packages will contain the following:

i. Narrative Summary (NARSUM), see AFPC Medical Retention Standards for current version to be used

ii. Associated clinical notes, consult reports and/or ancillary studies.

iii. A current AF Form 469 (reviewed IAW AFI 48-133).

iv. IRILO Checklist located at AFPC Medical Retention Standards:

B. Uploading Documents into ECT. AFRC/SGO requires documents uploaded in PDF format only; per DAFMAN 48-108 use only the AF-approved forms package. Microsoft

Word documents are directly forbidden because there is no reliable method of locking the form so that it cannot be changed by the user; see AFI 33-360, *Publications and Forms Management*.

C. Assignment Limitation Codes (ALC). ALCs are assigned by AFRC/SGO during one of the fitness for duty processes (I-RILO, ND-DES, or MEB-IDES) when members are granted a retention waiver, found fit for service and returned to duty. The ALC is meant as a tool to stratify the medical risk associated with the underlying condition for both the assigned Reserve Commander who will fill deployment tasking's and for the gaining COCOM that will employ member for mission execution.

D. Location of Official Fixed MTF. For a list of fixed MTFs, refer to the AFPC Medical Retention Standards Branch page of the AFMS KX.

E. Non-Emergent Elective Surgery Procedures. All Reserve members within 6 months of leaving a period AD orders must have approval from AFRC/SGO before undergoing any non-emergent elective surgery. This request must be input into ECT. This request is oftentimes forgotten about, please educate all UHMs, UDMs and CCs of the requirement and make sure you advise members they must keep you aware of surgeries occurring while they are on AD orders; this constitutes a change in the health status that must be reported to their RMU.

F. Deployment Waivers. Members on an ALC or DW code require close review, and many will require a deployment waiver based on their ALC stratification or DW code and the reporting instructions issued by the COCOM. There are also instances when members without an ALC may also require a deployment waiver. If a member will be going to more than one OCONUS Command, then a waiver for each location is required. Refer to AEF Online and AFRIT for the latest COCOM requirements and waiver request templates.

i. All ALC C-1 require a waiver for any OCONUS tasking to a location without a fixed MTF.

ii. All ALC C-2 require a waiver for any OCONUS Deployment, TDY, or PCS regardless of length of tasking or fixed MTF status.

iii. All ALC C-3 require a waiver.

iv. All Deployment Waiver requests must be routed through ECT to HQ AFRC/SGO. Deployment Waivers will not be submitted directly to the gaining COCOM.

Note: *SGO review, and coordination is crucial to ensuring a quality, all-encompassing product is submitted to the COCOM/SG for adjudication. Due to the variances in requirements and formats amongst the COCOMS, multiple agencies involved in the deployment waiver process and uniqueness of AFR cases due to PCM typically being a civilian provider, the RMU to SGO submission will ensure proper routing and quality of product first time though. SGO maintains contact and liaison with the COCOM/SG offices to ensure this standard is agreeable. Also note*

the submission at 120 days out to SGO is specifically meant to allow SGO and RMU collaboration in preparation of an adequate package for submission to the COCOM at 90 days out.

G. Deployment Waiver Processing Timeline. Submit case through ECT at 120 days from of departure but no later than 75 days. If less than 75 days notification will need to be sent to the Manager, AFRC/SGO at AFRC.SGO.PhysicalStandards@us.af.mil with a reason explaining why the case was not processed before the required timeframe. HQ AFRC/SG: 7-10 days process.

H. Deployment Waiver Documents Required. First and foremost, all RMUs will include all supporting records, forms, checklist as mandated by the applicable COCOM waiver guide instructions.

i. Most current COCOM specific checklist/waiver support documents.

ii. If member is going to dual location submit both MAJCOM/COCOMs checklists and supporting documents within the same ECT case and make sure the need for dual locations is documented in the Deployment Waiver Med Tech tab in the "Line Remarks."

iii. Most recent NARSUM for members who completed a fitness for duty process and were returned to duty with or without an ALC.

iv. Most recent Return to Duty with or without an ALC letter from AFRC/SGO.

v. Current AF Form 469 and/or AF Form 422, cannot be working copy.

vi. Current clinical documentation

vii. RMU Provider must click "validate" on the checklist prior to submission; do not scan or print to adobe. The top blue banner should be present and reflect that the signatures are still valid.

I. Medical Hold Clarification. Per DAFMAN 48-108 Medical Hold is the method by which a member is retained in the service to permit MEB/IDES processing when the member overcomes the presumption of fitness. DAFMAN 48-108 spells out the when it should not be used; the presumption of fitness standard and that AFRC/SGO is the approval authority for all AFR assigned personnel to include AGRs. The following reserve specific clarification is meant to clarify exactly when it is needed and how to handle situations where it is not required but another action meets the same purpose.

ii. When Medical Hold is needed.

a. The RMU or ADMTF (for supported AGRs) should request from AFRC/SGO by utilizing the procedures noted in DAFMAN 48-108 for what is required in a Med Hold request.

b. Enlisted members are entitled to MEB/IDES process (meaning a DQ condition with a LOD-Yes) and approaching their High Year Tenure Date (HYTD). AFRC/SGO will determine if the presumption of fitness applies and if med hold is granted, will notify the appropriate personnel office to extend the HYTD.

c. Officer members are entitled to MEB/IDES process (meaning a DQ condition with a LOD-Yes) and approaching their Mandatory Separation Date (MSD). AFRC/SGO will determine if the presumption of fitness applies and if med hold is granted, will notify the appropriate personnel office to extend the MSD.

iii. When Med Hold is not required.

a. When member is undergoing a Non-Duty Disability Evaluation System (NDDES) case (DQ condition has no LOD or was found not in the line of duty). There is no disability processing associated with this process, even when entered into the Physical Evaluation Board (PEB) it is for a "fitness" determination only IAW AFI 36-3212.

b. When approaching a voluntary retirement. If the retirement IS NOT mandatory and member desires to have either an MEB/IDES or NDDES cases completed before separating they can withdraw their retirement. This is a personnel action; defer members to their FSS and/or Unit/CC. **Process the case as normal until in possession of a separation order directing transfer of the service treatment record.**

c. When approaching end of enlistment. There are already well defined personnel procedures in place that permit extension rather that full re-enlistment for members on a DLC. Furthermore, in order to reenlist, members must have medical clearance and this should not be provided if member is on an AAC 31 or 37 and pending an MEB/IDES or NDDES. In these instances the FSS and CC can extend the enlistment to allow completion of the case. If returned to duty, the member may request a re-enlistment, but Medical Hold is not required in these instances.

Note: *Medical Hold should not be confused with MEDCON. Med Hold retains a member in the service for MEB/IDES processing and AFRC/SGO is the approval authority. MEDCON is medical continuation orders for retaining members on active-duty orders of some sort to satisfy medical treatment as well as pay and allowance benefits. This is managed/routed via the Air Reserve Component - Case Management Division (ARC-CMD).*

J. Non-Physician Providers Preparing the NARSUM. DAFMAN 48-108, Chapter 3, 3.3. Currently states "For ARC, either a psychiatrist or a psychologist with a doctorate must sign NARSUMs for mental health diagnoses that require non-duty related full case processing to the PEB. (T-2)."

i. A T-2 waiver has been issued by the AFRC/CC delegated authority (AFRC/SG) to allow a privileged mental health provider to sign mental health NARSUMs, current version of the T-2 waiver can be located here.

ii. Mental Health NARSUM Requirements for Non-Duty Disability Evaluation System (NDDES) process (IRILO, NDDES, MEB/IDES) Summary:

a. IRILO stage; whether it is an ILOD or NILOD in this phase the mental health NARSUM is NOT required nor is the military mental health evaluation (MMHE). The RMU may request a MMHE if deemed necessary and AFRC/SGO reserves the right to request one as well. The standard NARSUM template may be used in this stage. If disqualified in this stage, members are referred to one of two full case types in which a mental health NARSUM will be required.

b. MEB/IDES stage; cases with a mental health diagnosis requires a separate mental health NARSUM, all NARSUM are located on the on the AFPC Medical Retention Standards KX.

c. Non Duty Disability Evaluation System phases; cases with a mental health diagnosis requires a separate mental health NARSUM, all NARSUM are located on the on the AFPC Medical Retention Standards KX. As noted above a waiver exists for the psychiatrist or a psychologist with a doctorate co-signature requirement.

K. RMU Coordination with ADMTFs. RMUs must stay engaged with the MTF and PEBLO that services them for MEB/IDES processing. Participating in the host AMRO Board is the easiest way to do so. RMUs ae ultimately responsible for the I-RILO phase and submission to AFRC/SGO. Staying engaged with host PEBLO and AMRO Board when an I-RILO is being prepared, especially those that are vectoring to a DQ, and MEB/IDES referral will allow mitigation of LOD issues early with the PEBLO that may delay MEB/IDES after AFRC/SGO adjudication. RMUs should actively engage with their host from the point an I-RILO is directed by the RMU AMRO through to MEB/IDES hand off to the MTF so any LOD related concerns/LIMFACS can be addressed in advance. The end goal is a seamless transition from the Pre-IDES (I-RILO) phase to entrance into MEB/IDES following a DQ disposition by AFRC/SGO.

L. Procedures for Member in FFD process, non-compliant with submission of records or DD Form 2870 ROI. RMUs will send a certified mail memorandum requesting pertinent medical information or DD Form 2870 ROI. If the FFD case is specifically a ND-DES case this request will also include the applicable fact sheets and

elections as required for a ND-DES case (reference Chapter 39). This initial memorandum will give member a 60-day suspense. If no response is received the RMU will send request again via first class mail (non-certified mail) with another 60-day suspense. Entry in the STR (AHLTA/MHS Genesis) or SF 600 uploaded to HAIMS and AMRO notes will be recorded when each is sent, to included suspense date. If no response from member is received following the allotted 120 days, the RMU will take the following steps:

a. Maintain member on AAC 37

b. Issue RMU/CC memorandum to the member's Commander, see Attachment 15. RMU should provide the original memorandums sent to the member and certified mail receipts to the CC as attachment to this memorandum. RMUs should retain copies of these.

c. Make an entry in the STR (AHLTA/MHS Genesis) or SF 600 uploaded to HAIMS; "*Member has not complied with request for supporting medical records (detail what records are still lacking), in support of the required fitness for duty assessment, member commander notified for administrative action, no further action can be taken at this time by XXRMUXX. AF Form 469 AAC 37 will be maintained current if member remains in service/assigned, AMRO board note will be recorded."*

d. This entry in the STR should be accompanied by the memos sent to the member as well as the RMU/CC to member/CC memo.

e. Make an entry in the AMRO Board notes noting member non-compliance and deferral to the CC for further actions.

f. Annually as long a member remains assigned and in ASIMS, when renewing the AAC 37, reissue the RMU/CC memo to the member commander, file memo and make another entry in the in the STR restating the previous entry, and make another AMRO Board note entry as well, repeating previous.

i. If member is physically present/available when first request is made, the same memorandum should be issued, and procurement of members signed acknowledgement of receipt should occur. This starts the first 60-day suspense. If another 60-day suspense is required, it is recommended RMUs use the certified mail delivery. The end goal is member is allotted 120 days, this requirement is clearly communicated and recorded so that if member does not comply the necessary evidence and support that all attempts were made to afford member due process occurred and will better enable the CC to take the next actions. Use of email and delivery/read receipts or member acknowledgement via reply to in lieu of mail should be discussed with the JA, if this is deemed acceptable this is a permitted deviation from the postal service mail

options. Finally, RMUs may deviate from the 120 days for valid reasons when member is compliant but factors beyond their control result in records not being submitted/available within 120 days (i.e., civilian provider not response to ROI requests or appointment availability for necessary consult). In these instances, RMUs will record adjusted suspense in memo or email (if allowed per discussion with local JA) to member, entry in STR and AMRO Notes.

Chapter 25
AFI 48-116, *Food Safety Program*

1. References / Further Reading.

A. AFI 48-101, *Aerospace Medicine Enterprise*

B. AFMAN 48-147, *Tri-Service Food Code*

2. Self-Assessment Communicators.

A. 48-116, *Food Safety Program* - NA for Collocated, for stand-alone AFRC installations, the BE/PH should run the SAC, RMU/SGP should validate.

3. Introduction. This instruction applies to all Regular Air Force (RegAF) personnel, AF Reserve Command (AFRC) and Air National Guard (ANG) personnel, direct reporting units and field operating agencies.

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 26
AFI 48-117, *Public Facility Sanitation*

1. References / Further Reading.

A. AFI 48-116, *Food Safety and Inspection Program*

B. AFI 48-144, *Drinking Water Surveillance Program*

2. Self-Assessment Communicators.

A. *AFI 48-117, Public Facility Sanitation* - NA for Collocated, for stand-alone AFRC installations, the BE/PH should run the SAC, RMU/SGP should validate.

3. Introduction. This AFI prescribes the minimum sanitary standards for public facilities on Air Force installations. This instruction applies to all Air Force (AF) personnel, Air Force Reserve Command (AFRC), Air National Guard (ANG), direct reporting units and field operating agencies.

4. Guidance. See AFI for further guidance, AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 27
DAFI 48-122, *Deployment Health*

1. References / Further Reading

A. AF Deployment Related Health Assessment Guide

B. AFI 10-250, *Individual Medical Readiness*

C. AFI 10-403, *Deployment Planning and Execution*

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

E. AFMAN 41-209, *Medical Logistics Support*

F. AFMAN 41-210, *TRICARE Operations and Patient Administration Functions*

G. AFI 44-119, *Medical Quality Operations*

H. AFI 48-170, *Preventive Health Assessments*

I. AFI 44-171, *Patient Centered Medical Home and Family Health Operations*

J. AFI 44-172, *Mental Health*

K. AFMAN 47-101, *Managing Air Force Dental Services*

L. AFI 48-101, *Aerospace Medicine Enterprise*

M. DAFMAN 48-123, *Medical Examinations and Standards*

2. Self-Assessment Communicators

A. 48-122, Deployment Health, Medical (RMU responsible)

B. 48-122, Deployment Health, Unit Commander (RMU and all line units responsible)

3. Introduction.

A. The Deployment Related Health Assessment (DRHA) Program is an essential component of deployment health and an RMU cannot adequately manage Airmen before and after a deployment if they do not carefully read and adhere to program requirements outlined in DAFI 48-122.

B. Deployment-Related Health Assessments Program. AFRC/SG3P will no longer maintain an extensive folder on the KX with tools in support of the DRHA program. Instead RMUs should bookmark and refer to the **AFMRA DRHA Program Office KX**. The AFMRA DRHA Program Office is the primary content generator and subject matter experts for this program. Tools and resources that will assist RMUs in the tactical level execution of the DRHA program will be found here. AFRC/SG3P routinely coordinates and reviews AFRC specific products with the AFMR DRHA Program Office for utility in AFR RMUs and AFR specific documents are available. AFRC/SG3P will only host AFRC specific guidance/direction in the TIG or on the AFRC/SG3P KX, which should be minimal.

4. Guidance

A. The RMU full time staff is the linchpin in assuring Reserve Service members are medically managed appropriately prior to and upon return from a deployment of greater than 30 days. Of importance, the following tasks must be accomplished daily:

i. The RMU full time staff MUST monitor the ASIMS Open List Report to identify Airmen who have not accomplished the person-to-person encounter with the RHRP-contracted call center and instruct members to contact the call center to complete the person-to-person encounter.

ii. The RMU full time staff MUST also monitor the ASIMS Closed List Report to identify Airmen who have completed their DRHA medical encounter with the RHRP-Contracted Call Center privileged healthcare provider. The RMU full time staff must carefully review the DRHA form to determine if the healthcare provider has recommended a medical referral. The RMU full time staff is responsible for initiating a Line of Duty determination and coordinating and assuring the member schedules and receives follow-up medical care as recommended by the provider. Also, the RMU full time staff must either, 1) print a hard copy of the DRHA form and file in the member's Electronic Health Record (EHR) via upload to HAIMs or 2) accomplish an electronic encounter in AHLTA or MHS Genesis documenting the completion of the DRHA. ASIMS is not part of the EHR, assessments accomplished in ASIMS are therefore not part of the EHR. The DRHA program requires the encounter be recorded/filed in the EHR, accomplishing in ASIMS alone does not meet this requirement.

iii. In partnership with the member's Unit Deployment Manager, the RMU full time staff monitors ASIMS to assure members complete Deployment-Related Health Assessment (DRHA) #1, #2, #3, #4, and #5 and receive follow-up medical management as necessary.

iv. See DAFI and DRHA guide for further guidance.

Chapter 28
DAFMAN 48-123, *Medical Examinations & Standards* / Medical Standards Directory

1. References / Further Reading.

A. DoDI 6130.03, Vol. 1, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*

B. DoDI 6130.03, Vol. 2, *Medical Standards for Military Service: Retention*

C. AFI 48-133, *Duty Limiting Conditions*

D. AFI 10-403, *Deployment Planning and Execution*

E. AFMAN 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Aviation Badges*

F. AFI 36-2910, *Line of Duty Determination*

G. AFMAN 36-2136, *Reserve Personnel Participation*

H. AFI 44-119, *Medical Quality Operations*

I. AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*

J. DAFMAN 48-108, *Physical Evaluation Board Liaison Officer (PEBLO) Functions: Pre-Disability Evaluation System (DES) and Medical Evaluation Board (MEB) Processing*

K. AFI 48-170, *Preventive Health Assessment*

L. AFMAN 47-101, *Managing Air Force Dental Services*

M. AFI 48-101, *Aerospace Medicine Enterprise*

N. AFMAN 48-149, *Flight and Operational Medicine Program (FOMP)*

2. Self-Assessment Communicators.

A. 48-123, *Medical Exams and Standards* (Tracked by RMU with Aerospace Medicine mission)

3. Introduction. Air Force Reserve Command (AFRC) utilizes this instruction along with supplements to provide specific guidelines for the administration of Air Reserve Component (ARC) personnel

4. Guidance. DAFMAN 48-123 provides general information and administrative procedures for medical examinations and standards.

A. RMU provider review of civilian records. Review of civilian records as part of military medical readiness assessments is a core function of the AOME RMU. As such the following validation/documentation of this review should occur.

i. RMUs that have fully electronic process (AHLTA/MHS GENESIS):

a. Upon receipt of civilian medical documentation, RMUs will ensure a process is in place to have civilian documentation wet or digital signed by reviewing RMU provider prior to uploading into HAIMS. An AHLTA/MHS GENSIS encounter will annotate provider's review comments regarding civilian documentation addressing medical readiness of the service member.

ii. **RMUs that do not have a fully electronic process (utilizing paper based SF600):**

a. Upon receipt of civilian medical documentation, RMUs will ensure a process is in place to have civilian documentation wet or digital signed by reviewing RMU provider prior to uploading into HAIMS. A SF600 will accompany the civilian documentation annotating review of civilian documentation addressing medical readiness of the service member. Both documents will be uploaded as a single PDF into HAIMS.

B. Commissioning Physical. AFRC/SGO is the certification/waiver authority for currently serving enlisted ARC members applying for commissioning. The Accession Medical Waiver Division (AMWD) is the certification/waiver authority for non-prior service applicants. The following documentation must be submitted by the RMU through PEPP for currently enlisted AFR commissioning applicants.

i. Option 1. The member and RMU will complete a DD 2807-1 in PEPP and attach the most recent PHA, AF Form 422, and all supporting clinical records for any positive items in medical history. The RMU will prepare the shell of a DD Form 2808 in PEPP with the demographics (block 1-16) only and route with the DD Form 2807-1. AFRC/SGO will stamp the DD Form 2808.

Note: *AFRC/SGO reserves the authority to request a full commissioning exam at their discretion following review of a case submitted under option 1. See DAFMAN 48-123 for further guidance.*

ii. Option 2. The RMU accomplishes a full commissioning exam in PEPP (DD 2808/2807-1), following the Initial Fly and Special Operations Physical Exam Matrix (PEM) using the column titled OCONUS Enlistment & Commissioning criteria. OCONUS enlistment & commissioning criteria will be used by the AFR

for all CONUS and OCONUS exams. AFRC PEARS guide will no longer be used as guidance.

Note: *Individuals at the RMU must request access to HPWS BOMC site. See the Initial Fly and Special Operations Physical Exam Matrix (PEM) on the HPWS BOMC website.*

C. IAW DODI 6130.03, Vol. 1, Appointment as a commissioned officer in the AFR requires members to meet accession standards or receive a waiver from the designated Service Waiver Authority (SWA). In the case of all AFR members the SWA is either the AMWD (non-prior) or AFRC/SGO (Prior service).

i. RMUs conducting Commissioning exams (whether option 1 or 2) must familiarize themselves with DODI 6130.03, Vol. 1 criteria and understand that Accession standards apply. Also, keep in mind and recognize that retention standards apply to service members continuing service in the current office, grade, rank, and rating for which they are trained and qualified. Previously unidentified conditions brought to light during a commissioning exam for a currently serving enlisted member must be screened for both accession (to commission) and retention (Continued military service IAW DODI 6130.03, Vol. 2).

ii. Members applying for Commission are entering a new status, hence the requirement to meet higher standards. Accession standards are more stringent across the board and a condition that is not disqualifying for retention may very well be problematic under accession standards.

iii. RMUs must be able to understand the difference and be able to articulate this to members so expectations can be managed.

iv. If a new condition is identified during the exam that is a retention issue the RMU should make the appropriate adjudication prior to submitting commissioning application.

D. Military Entrance Processing Station (MEPS).

i. MEPS Disqualification. In most instances the Reserve Medical Units (RMUs) cannot override a previous MEPS disqualification. Individuals who wish to present additional medical information on their behalf must be referred to the MEPS.

ii. No profile or disqualification done at MEPS will be changed, except as follows:

a. AFRC/SGO, MEPS, and RMUs are authorized to change profiles on individuals who have exceeded body fat standards but have since come within standards.

b. When a RMU changes the PULHES, and qualification as noted above they will provide two stamps on the front of the DD form 2808 with verbiage as follows:

1. First:

{UNIT NAME}
{XXX AFB}, {STATE}
{TODAY'S DATE}
Medically Qualified for USAFR Enlistment/Commission Meets Weight/Body Fat Standards

2. Then, add a new PULHES with adjustment to the P to a "1":

{UNIT NAME}
{XXX AFB}, {STATE}
REVISED USAF PROFILE
{TODAY'S DATE}

P	U	L	H	E	S
1	1	1	1	1	1

Note: *The RMU may only update the "P", the ULHES values must be transcribed from the MEPS exam.*

c. AFRC/SGO and RMUs are authorized to change X-Factor on individuals who are re-evaluated by the Installation Fitness Center and provides the results to the RMU for verification. A copy of the MFR provided from the FC will be uploaded in to the STR and/or HAIMS.

E. Accession Waivers for Members in Delayed Entry Program.

i. Accession Medical Waiver Division (AMWD).

a. The USAF has established the Accession Medical Waiver Division (AMWD), and it is presently fully operational.

b. The AMWD is the Service Waiver Authority for ALL accession medical waivers for ALL Air Force members, (AD, AFR and ANG).

c. AFR RMUs are not typically involved in the accession process, as such this pipeline predominantly resides between MEPS or BMT/Tech School MTFs and the AMWD. However, members who have cleared MEPS, have been assigned to the AFR, but have not departed for BMT (typically assigned within your Wing to the Developmental Flight), who present with a medical condition that does not meet accession standards require

waiver consideration prior to BMT departure. These members are still under "ACCESSION" not "RETENTION" standards. RMUs are responsible, once becoming aware of conditions that do not meet accessions standards, for submitting the case to the Waiver Authority = AMWD.

d. RMUs identifying a member in the developmental flight with a condition that does not meet accession standards will submit the following to the AMWD via their organizational email box "AFRS/AMWD Workflow" AFRS.AMWD.ACCESSION@us.af.mil. When submitting a case to their org box, be sure to identify "RESERVE" in the subject line for expedited routing to the team handing AFR cases.

1. The original certified entrance exam (2808 and 2807-1)

2. All clinical records associated with the newly identified condition for which the member requires an accession waiver.

3. MFR requesting waiver consideration will include:

a. HISTORY OF PRESENT ILLNESS:

b. MEDICAL/PSYCHIATRIC PAST HISTORY:

c. CURRENT MEDICATIONS:

d. SUBSTANCE USE: (if applicable)

e. MENTAL STATUS EXAM:

f. PSYCHOLOGICAL TESTING PERFORMED:

g. HOSPITAL/OUTPATIENT TREATMENT COURSE:

h. CURRENT DIAGNOSIS & DODI REFERENCE:

i. PROGNOSIS & ASSESSMENT:

Note: *RMUs will receive a MFR back from the AMWD with their findings. If an accessions waiver is granted, file in the STR and update the applicable records and systems. If the waiver is not granted, notify and provide the servicing FSS the MFR as well. Member will require entrance into the separation process you must positively hand this off for the next separation action to occur.*

Note: *The AMWD DOES NOT review Palace Chace/Palace Front, or any other members under retention standards when entering the AFR (Members in the IRR less than 12 months for example).*

F. AGR Certifications. These medical certifications are for members entering AGR tours or starting follow-on tours. Any member with an ALC or those being assigned to a MAJCOM or higher position require certification from AFRC/SGO.

i. A review of the EHR and STR is required.

ii. The medical certification request will be submitted to the AGR Medical Certification queue in ECT.

iii. RMU Providers may certify members under retention standards who are not on an ALC or entering a Wing level or below AGR position.

G. Medical Examination/Assessment/Misc.—Accomplishment and Recording and Physical Examination Quality Control.

i. All initial physical exam types will utilize the Initial Fly and Special Operations Physical Exam Matrix (PEM) for Term of Validity and required exam components. AFRC PEARS guide will no longer be used as guidance. Individuals at the RMU must request access to HPWS BOMC site where the current PEM will be maintained.

ii. For any exams requiring certification from an authority other than AFRC/SGO as designated by DAFMAN 48-123, Attachment 2; the RMUs will still forward the exam to AFRC/SGO. AFRC/SGO will accomplish an initial review, then route to the appropriate certification authority.

iii. Accession Examinations. Local accession physical examinations by RMUs should be limited to, 1) Commissioning exams for currently serving enlisted to officer, 2) Combination exams (NPS commissioning with IFC3 or RTFS) which must meet DoDI 6130.03 Vol 1 and 2 and MSD standards. Any deviation from these DoDI standards requires a waiver from AFRC/SG. RMUs SHALL NOT accomplish NPS enlistment or commissioning exams otherwise, these will be accomplished at MEPS. For currently serving enlisted to commissioning applicants, if no accession waiver is needed follow directions for option 1 at Section 4.A.i. above. If an accession waiver will be required option 2, at Section 4.A. ii. is required.

iv. Physical Examination Processing Program (PEPP). PEPP consists of a web-based DD Form 2808, Report of Medical Examination and DD Form 2807-1, Report of Medical History. It has the capability to forward the DD 2808 and DD 2807-1 electronically to certification authorities. PEPP has attachment capabilities. Waivers will not be initiated from PEPP.

a. PEPP allows applicants to go to a URL OUTSIDE of the AF portal to complete a pre-exam medical history report prior to arriving at your RMU. URL for applicants is https://pepp.sso.cce.af.mil/portal/pepp/pmhe/

b. An AF Portal account is required to access PEPP. Questions regarding access should be referred to the local PEPP administrator who will contact AFRC/SGO though the AFRC.SGO.PhysicalStandards@us.af.mil organizational box. AFRC/SGO will forward as deemed necessary to the service center.

v. Initial Flying Class I and II (FS) Physicals. All Initial Flying Class I Undergraduate Pilot Training (UPT) applicant physical examinations for wing sponsored Reservists will be accomplished in combination with Medical Flight Screening (MFS) at Wright-Patterson AFB, OH. Civilian applicants will be referred to an AFR recruiter. All IFC II Flight Surgeon (FS) exams will be conducted at Wright-Patterson AFB similar to the IFC I exam process unless SG3P has provided in writing on a case-by-case basis approval. Applicant(s) should contact the local Reserve Medical Unit (RMU) for questions. Instructions for obtaining these examinations can be found HERE.

Note: *AFRC PEARS guide will no longer be used as guidance. Individuals at the RMU must request access to HPWS BOMC site. See the Initial Fly and Special Operations Physical Exam Matrix (PEM) on the HPWS BOMC website.*

a. The RMU or Recruiter. Review the following forms for completeness:

1. The member must review the "IFC I Pre-Screen" directions at https://www.afrl.af.mil/711HPW/USAFSAM/FCI/ and submit a completed "Personal Data Form" to the RMU or Recruiter.

2. Instructions on how to schedule an appointment and for actual appointment at: https://www.afrl.af.mil/711HPW/USAFSAM/FCI/

3. Previous DD Form 2808 and 2807-1 physical package (usually from MEPS, the original Commissioning physical for entry in the AF, or a previous PEPP package) including supporting documents (CCT, EKG, etc.) This may be a DD Form 88/93 for certain legacy physical exams.

4. A new DD 2807-1 with only pages 1 and 2 completed. This is to expedite processing at MFS where the MFS examiner will complete page 3.

b. Documentation Submission. These documents are submitted to AFRC/SGO at AFRC.SGO.PhysicalStandards@us.af.mil for review and

appointment scheduling at MFS. The RMU or Recruiter shall not circumvent AFRC/SGO and contact MFS directly. Ideally all documents should be combined into a single file with the file name as the initial of the last name and the last four digits of the SSN for example "S1234.pdf"

c. Scheduling. The RMU or Recruiter should provide AFRC/SGO the desired dates for scheduling. MFS requires at least a minimum of 30 days advance notice for scheduling and 45 days advanced notice is customary.

1. AFRC/SGO will notify the RMU or Recruiter of any required corrections and notify of dates the member is scheduled.

2. The TDY duration should be allocated for five days. Though applicants historically often complete their examinations within fewer days, MFS cannot guarantee completion timelines as patient circumstances vary on an individual basis.

vi. Initial Flying Class III Examinations.

a. IFC III at RMU. All RMUs should make every effort to conduct IFC III exams at home station to keep FS and Med Tech training requirements current. IFC III exams are a core competency for Flight Surgeons and 4N0X1Fs. Therefore, RMUs WILL maintain and complete some IFC III exams locally. RMUs must retain an adequate caseload of their own to meet training/competency needs of their Officer and Enlisted Aerospace Medicine section staff.

b. IFC III at 559 AMDS, Lackland AFB. The Scheduling Procedures for IFC III appointments with the 559 AMDS at Lackland AFB have been updated and uploaded into the AFRC KX. To expedite IFC III scheduling at Lackland, coordination took place between AFRC/A3, AFRC/SGO, and the AFRC POCs at the 559th AMDS to alter the previous scheduling procedures. Wait times for appointments were increased mainly due to the reviews conducted at AFRC/SGO and the subsequent corrections sent back to the requesting RMU. With the concurrence of AFRC/A3, AFRC/SGO, and the 559th AMDS, all requests will be sent directly from the Operational Units to the POCs at the 559th. Reserve Medical Units are no longer required to send the IFC III scheduling requests or conduct medical record reviews on those applicants but should maintain situational awareness on what appointments are being requested/scheduled.

Note: *IFCIIIs and other occupational exams may require Strength Aptitude Testing (SAT) per AFI 36-2101 and AFECD Attachment 4.*

Note: *Incomplete exams or those no longer pursuing Fly/SOD qualification exams in PEPP should be forwarded to AFRC/SGO for final disposition, see DAFMAN 48-123, Chapter 5.*

H. Commissioning/Flight Clearance Disqualifications. Options for member to appeal a disqualification finding are as follows:

i. Appeal process. When a MAJCOM/SG has waiver and/or certification authority, that MAJCOM/SG keeps the authority even after a disqualification IAW DAFMAN 48-123. AFRC/SGO will consider appeals of any case. The previous disqualification must be addressed, and re-submitted by a privileged military provider (i.e., not the member).

a. The military provider should convey why the new case should now be cleared and why the earlier disqualification is no longer valid. All reasons for disqualification must be acknowledge in the new case.

b. AFRC/SGO dispositions are evaluated solely on medical criteria.

ii. Initial Flying Clearance (IFC), IAW DAFMAN 48-123. Only AFMSA/SG3PF has authority to overturn an AFRC/SGO disqualification for IFC and approve an IFC case. However, AFRC/SGO must first review the case and may choose to again disqualify it at the lower level and not forward the case to AFMSA/SG3PF IAW DAFMAN 48-123. Only if AFRC/SGO recommends the case be overturned will the case be forwarded to AFMSA/SG3PF. AFRC/SGO may forward any "controversial" cases, however the determination of whether a case is indeed controversial is at the discretion and opinion of the AFRC/SGO.

I. Member Advocate for Appeal. If a member is not happy with a determination made by AFRC/SGO they may appeal through the following avenues:

i. Local unit leadership, through the Exception to Policy (aka ETP) process (AFI 36-2101).

ii. Congressional officials (Representatives and Senators), through Congressional Inquiry.

iii. The Air Force Board for Correction of Military Records (aka BCMR).

J. How Disqualification Affects Members. Medical criteria for Commissioning and IFC are separate from the Retention (continued duty) or existing (trained) flyers. The USAFSAM flying waiver guide, DAFMAN 48-123, and the Medical Standards Directory (MSD) explain that applicants to an untrained position (e.g., IFC, retraining, Commissioning) have higher standards and greater scrutiny than already trained personnel currently in the position. Following an AFRC/SGO disqualification for a desired position, the local FS/Physician should review the reason for the disqualification and determine if the member would require additional AAC 31/37 action. Typically, AFRC/SGO will provide a separate memo to the RMU/MTF directing IRILO processing for the cases AFRC/SGO believes such action is warranted.

K. When A Member Wants to Talk to AFRC/SGO Physician. AFRC/SGO staff are happy to discuss cases with RMU/MTF staff or local Unit leadership, especially as it is an opportunity to discuss the policy or regulatory reasons for an action. RMU/MSME staff and Squadron-level leadership should first try to coordinate with the AFRC/SGO technicians through our organizational email at AFRC.SGO.PhysicalStandards@us.af.mil The Flight Surgeons within AFRC/SGO usually only coordinate with other Flight Surgeons or Clinicians (MD, DO, NP, PA, etc.), or Wing-level leadership. Unfortunately, AFRC/SGO does not have the manpower to justify every incidence of disqualification to each individual patient and relies on the RMU/MTF to inform and explain medical determinations to the member. AFRC/SGO staff generally does not interact directly with the individual patients, as it is the responsibility of the servicing RMU/MTF or FSS/MPF.

L. Term of Validity of Medical Examinations. The following information discusses Term of Validity, Administrative Validity, and Flying training.

i. See the Initial Fly and Special Operational Physical Exam Matrix (PEM) & DAFMAN 48-123 for Term of Validity for all IFC exams. The PEM can be found HERE.

ii. All flight surgeon candidates for Aerospace Medicine Program (AMP) must possess a valid and current IFC II physical, regardless of the increment. This does not exempt member from the annual PHA.

Note: *APA and ANP candidates require "operational support flying duty" examinations. (See DAFMAN 48-123, Chapter 5 for exam requirements).*

iii. Initial qualification for flying duty:

a. Inter-service transfer rated physical cases must include the following information in the comments section of the DD2808: 1) previous aircraft flown, 2) previous branch of service (AF, USMC, etc.), 3) previous AFSC(s), and 4) date member last flew in the performance of duties of last flying AFSC (Mmm YYYY).

b. Certification of the DD Form 2808 does not officially qualify a member for flying duty.

c. The validity of the exam is based on the certification date on the exam (DD Form 2808) IAW DAFMAN 48-123.

d. Actual qualification and issuance of the Air Force Aeronautical Order (DAF AO) will not occur until the DD Form 2992 is signed by the flight surgeon.

e. RMU will issue the DD Form 2992 by the next UTA following certification of an initial flying exam. If member is a current AF member the RMU will copy the stamp verbiage from the PEPP 2808 into the Remarks section of the ASIMS issued DD form 2992. If member is not in ASIMS, the RMU will issue the hard copy DD Form 2992 with the certification stamp verbiage in the Remarks section as well. The HARMS office will refer to the date in the Remarks section not necessarily the date on the 2992 when determining the date member was medically certified for flying duty and awarding of the AO.

M. RTFS after medical disqualification or break in service. IAW DAFMAN 48-123 and AFMAN 11-402.

i. If medical disqualification/break in service is less than one year, the local fight surgeon clears the member for flying duty.

ii. If medical disqualification/break in service is greater than one year will require AFRC/A3 requalification with MAJCOM SG medical certification.

iii. AFRC/SGO medical recertification must be administratively processed through PEPP (and AIMWTS, if a waiver is needed). Consider this medical examination a continued flying duty standard, using "trained asset" criteria from the waiver guide, and the MSD FCII or FCIII standard depending on AFSC. A current Fly PHA + current DD Form 2807-1 + demographics-only DD Form 2808 via PEPP to AFRC/SGO for review and certification is sufficient in cases without significant change in health status over the greater than one year break in flying.

Note: *This process has taken the place of the previous RTFS columns in the old PEARS guide.*

iv. Cases must include the following information in the comments section of the DD2808:

a. Previous branch of service (USAF, USMC, etc.)

b. Previous AFSC(s)

c. Date member last flew in the performance of duties of last flying AFSC (Mmm YYYY).

v. Exercise your best judgment and perform other examinations that may be clinically indicated. As certifying and waiver authority, AFRC/SGO may require additional testing, examinations, or commentary to accurately adjudicate applicants.

vi. Once AFRC/SGO certifies the PEPP package, the RMU then creates the DD Form 2992 in ASIMS.

N. Waiver Guide Update Notes. Current updates will be maintained on the AFMRA Flight/Medicine Waiver Guide KX

O. Active Flying Waiver when transferring to AFR. Flyers transferring into the AFR do not need an immediate 'new' flying waiver unless the condition has changed or at the discretion of the local flight surgeon.

P. Aeromedical Consultation Services (ACS) Scheduling Times. For flying waivers that require ACS evaluation, whether initial or renewal, expect the appointment to be 30-60 days away (particularly for Neurology/Psychology conditions). Combine this with MAJCOM-level review and disposition and you may experience a 90 day wait from when you first submit a waiver. Therefore, we recommend you strive to submit such waiver renewal requests with ACS evaluation 120+ days in advance of any deadline.

Note: *This does not apply to waivers that are simply referred for ACS review, but only for in-person ACS evaluations. ACS stresses that you always accomplish and include the required documentation listed in the Waiver Guide. Failing to provide this documentation results in delays and addenda requests.*

Q. ECG Library. Any ECG on an Airman who is required to have a 2992 should be uploaded to the ECG Library. Instructions can be located on the AFMRA Flight/Medicine Waiver Guide KX, *Disposition of ECG Findings in USAF Aircrew.*

R. RMU Recommendation for Medical Disqualification. At any point when examining a Reserve flight surgeon learns of a potentially disqualifying condition on an initial flying class or commissioning physical, including during medical records review, or when obtaining a medical history, the flight surgeon may recommend disqualifying the member/applicant in PEPP.

i. If the FS feels a member should be disqualified, input physical into PEPP and select the DQ option and give specific justification, i.e. MSD or AFI reference for potentially disqualifying condition. An AMRO review should then be initiated to address any potential mobility restrictions or retention issues.

S. Federal Aviation Administration (FAA). FAA examinations will not be accomplished by Reserve physicians in military status. FAA examinations will not be accepted in lieu of the PHA nor annual flight and operational medical examination (FOME) requirements.

T. USAF Aircrew Corrective Lenses. Reference the AFMRA Flight Medicine Optometry KX for direction and policy on prescribing spectacles for aviators and RPA, and for soft contact lens program the Aircrew Contact Lens Program.

i. Authorized Spectacle Frames for USAF Aircrew. Those units that are not supported by active-duty equipment availability (non-collocated bases) must have

fitting sets for the new spectacles. The POC for fitting sets and improved aircrew spectacle is NOSTRA. Email: NOSTRA-CustomerService@med.navy.mil, DSN 953-7600 (Comm. 757-887-7600) Opt. 1.

U. Separation History and Physical Examination (SHPE). The SHPE is required for an AFR member for one of two qualifying periods of active duty; 1) Any order of 30 days or more in support of a contingency operation, or 2) Any period of orders (to include non-contingency MPA, RPA, AGR, VLPAD tours etc.…) of 180 days or more. SHPEs should be accomplished via one of four pathways:

i. Via ADMTF, best option for non-contingency qualifying periods of active duty, TRICARE eligible, empaneled to an ADMTF with an assigned PCM. AROWs reports are used to provide MyPers a listing of non-contingency eligible members and send monthly notifications direct to member. This list is also provided to AFRC/SG3P for sharing with RMUs as well so customers (CCs and members) can be advised of requirements.

ii. Via Department of Veterans Affairs (DVA). Also, more conducive to the non-contingency pathway when lead time prior to separation from a period of active duty is known and member is available in the area (not deployed). Member would work with ADMTF SHPE program manage to accomplish directly with VA, this option is generally reserved for those members that will make a claim, reference source DODI and DAFMAN for more detail on this pathway.

iii. Via RHRP, individual in-clinic. Contract exam with a provider near member home of record (within 50 miles) or location at the discretion of the member, good option for retuning deployers in small numbers that are not large enough to support a group event (iv below) and for which the ADMTF is not easily accessible (Standalones), or availability is limited in the time before member leaves downtime following redeployment.

iv. Via RHRP, Group Events. Best option for large groups of returning deployers. Coordination between AFRC/SG3P, RHRP vendor, Wing agencies (FSS, IPR, and effected units) is required to plan and schedule these events. AFRC/SG3P has a dedicated POC to monitor returning deployments and coordinate/assist RMU planning/execution with whichever pathways is utilized, especially in the event of a Group event. RMUs should be responsive to all outreach when planning for SHPE accomplishment and incorporating SHPE execution within the Wing post deployment process/model.

All of the above pathways maintain SHPE accomplishment via AD funding channels and should be exhausted prior to any accomplishment in house with the RMU and with AFR resources (time on UTA, AT, AFR funded full time staff) or funding via RPA. Only when the four noted pathways are inaccessible may the RMU accomplish with organic time/resources.

SHPEs should be completed prior to leaving the period of active duty and before members go on leave. For returning deployers the appropriate time to accomplish is during the post deployment down time which by policy member should remain in the local area of the assigned base and thus available and ideally not during leave time. Non-contingency SHPEs should be prior to terminal leave.

Finally, members in the MEB/IDES process will receive a C&P exam that meets the SHPE requirement.

V. Dietary Supplement Guidance.

i. IAW DAFMAN 48-123, dietary, herbal, and nutritional supplements can only be used by aircrew members with the approval of a flight surgeon.

ii. Additional information regarding dietary supplements is available from the USU Consortium for Health and Military Performance sponsored Human Performance Resource Center. Operation Supplement Safety https://www.opss.org.

W. Known Medical/Dental Conditions. Members who refuse required medical, surgical, or dental treatment or diagnostic procedures (for example dental carries or hernia that requires repair) will be placed on failure to comply status. The member is referred to his or her unit Commander to managed IAW AFI 36-3206, AFI 36-3208 and/or AFI 36-3209 as appropriate. Failure to obtain treatment to remedy such conditions may render an individual unsuitable (as opposed to unfit) for continued military service and subject to administrative action by their Commander.

X. IRR Members.

i. IRR Members' exam and medical standards application requirements for entry to the AFR per DAFMAN 48-123:

a. Applicants currently assigned to inactive or retired reserve or retired from active military service for less than 12 months since the date of separation on DD Form 214 or separation orders as applicable **use retention standards** from the medical standards directory (MSD). RMU will review current PHA and/or SHPE exam and conduct a full EHR review for entry to the AFR.

b. Applicants currently assigned to inactive or retired reserve or retired from active military service when more than 12 months have elapsed since the date of separation on DD Form 214 or separation orders as applicable use accession standards from DoDI 6130.03-V1. Members in IRR greater than 12 months must have a current MEPS Physical Examination forwarded to AMWD for adjudication for entry to the AFR if a waiver is required. If not, a waiver is required for accession, MEPS may certify.

Chapter 29
AFI 48-127, *Occupational Noise and Hearing Conservation Program*

1. References / Further Reading

A. DoDI 6055.12, *Hearing Conservation Program (HCP)*

B. AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted)*

C. AFMAN 41-210, *Tricare Operations and Patient Administration Functions*

D. AFI 48-101, *Aerospace Medicine Enterprise*

E. DAFMAN 48-123, *Medical Examinations and Standards*

F. AFI 48-145, *Occupational and Environmental Health Program*

2. Self-Assessment Communicators

A. Public Health Occupational and Environmental Health (PH OEH)

i. Collocated installations: Yes -Tenant RMU completes communicator and RMU SGP should validate communicator

ii. AFRC installations: Yes - BE/PH office completes communicator and SGP/IOEMC validates communicator

B. Occupational Health Shop-Level Checklist (OH Shop-Level)

i. Industrial shop supervisors complete

3. Introduction.

A. The audiometric testing of Traditional Reserve (TR) personnel associated with the Occupational Noise and Hearing Conservation Program is (in many cases) a substantial workload on the RMU.

i. The desired outcome for audiometric testing is to ensure timely awareness and documentation of an actual Air Force induced hearing threshold shift.

ii. Due diligence to appropriately ascertain whether the individual is exposed to hazardous noise by the Air Force is critical to mitigate the workload on the RMU while ensuring individual audiometric testing has a clear purpose.

B. The ARTs, as DoD Civilians "Monday through Friday," are predominately exposed as civilians. The host Occupational Health program owns all DoD Civilians on the installation.

4. Guidance

A. USAFSAM Hearing Conservation Program UTA Support.

i. An Audiologist at USAFSAM will be available for Hearing Conservation Program support/consultation during one AFRC UTA per month on Saturdays from 0800-1600 at 504-645-1344.

ii. Services available:

a. Hearing Conservation Program consults: regulation interpretation, program management, referrals/case-disposition suggestions

b. General occupational health consults that concern high noise, communications, safety concerns or fitness & risk evaluations

c. Basic DOEHRS-HC DR software actions (with referral to DOEHRS-HC Tier I support if errors are not addressable at USAFSAM)

d. DOEHRS-DR account management (approve accounts, change account access, etc.)

e. Basic requests for unit data or reports from DOEHRS-DR

f. Pre-scheduled education/training by DCO for units for 30 to 60 minutes on topics of concern or interest

B. DOEHRS.

i. Download v4.1.6.0 on the Data Repository website: https://doehrswww.apgea.army.mil/

ii. After CAC log in, select the DOEHRS-HC menu, then Installers.

iii. Download the application.

iv. Contact IT to install the update on your local system by following the Installation Guide for this version.

v. For further information, please contact the Hearing Conservation Team at USAFSAM by emailing USAFSAM.PHR.HC.WPAFB@us.af.mil

C. Overdue Occupational Health Exams.

i. Members with overdue occupational health exams (OHE), to include audiograms, should be placed on a Duty-Restricted (DR) AF Form 469 and a memorandum should be sent to the member's unit commander notifying them of the member's health risk.

ii. Recommended verbiage for the DR AF Form 469:

a. Member's failure to comply with required occupational surveillance examination renders the Air Force Medical Service unable to determine the Airman's current medical status. As such, member has been referred to their commander in writing for this non-compliance per AFMAN 36-2136. The following restrictions are placed on member to prevent occupational exposure and harm: no driving government vehicles, no working in highly safety sensitive tasks to include but not limited to confined space/at heights/on the flight line, no activities which require fine motor skills/precision work, no highly cognitive tasks unsupervised, no handling of sensitive, FOUO, or classified materials, no lift/push/pull more than 5 lbs., no prolonged standing greater 1 hour, no prolonged sitting greater than 2 hours, no repetitive motion, duty day not to exceed 8 hours, no working in locations where member is exposed to hazards as listed on their OHED/COEHR. Light administrative duties only.

iii. For a template of the memorandum for the member's unit commander, see Attachment 9 which may utilized to communicate occupational health exam deficiencies as well.

D. All individuals working in hazardous noise environments (as identified by the installation Bioenvironmental Engineering Flight or AFRC BE/PH office) will be included in the installation Hearing Conservation Program (HCP), and all protective elements of the program are expected to be applied.

i. The protective elements of the HCP are training and the issuance of appropriate hearing protective devices.

E. Audiometric testing becomes necessary when TR personnel are routinely exposed to hazardous noise more than 30 days/year. The shop supervisor of the hazardous noise workshop must make this determination and may communicate it directly to the RMU or indirectly, via the unit health monitor to the RMU.

i. USAF Combat Arms Training and Maintenance (CATM) TR personnel are typically exposed to hazardous noise at the firing range at or beyond the 30-day period.

ii. Effectively mitigating the noise exposure of CATM personnel can be challenging.

iii. CATM personnel should typically receive annual audiometric testing.

F. The supervisor must consider the time the TR spends on UTA and Annual Training not exposed to hazardous noise, to include the following: in office, commander's calls, meeting medical readiness requirements, fitness testing, classroom training, etc. The typical TR assigned to a hazardous noise environment will usually not perform actual work in the hazardous noise environment more than 30 days annually.

G. For other TR personnel, the 30-day rule allows the RMU to apply an abeyance to annual audiometric testing for those TR personnel not exposed (beyond accepted incidental noise exposure) to hazardous noise in their work area for more than 30 days/yr. All other protective elements of an effective HCP shall still apply in full for those TR personnel assigned to the hazardous noise associated work centers.

H. DoDI 6055.12, Hearing Conservation Program, 14 Aug 19 requires DoD personnel exceeding criteria in 3.2. (1) for at least 1 day per year to be enrolled in the Hearing Conservation Program. Prior to this, the AFR followed AFI 48-127, Occupational Noise and Hearing Conservation Program which required ARC personnel to receive an annual audiogram if exposed to hazardous noise for more than 30 days per year. AFRC/SG3P disseminated an email to all AFR Medical Units on 24 Oct 19 informing them of the new requirement and provided recommendations on how to implement the change in a phased approach. An occupational health data call was performed in Dec 19 and results revealed most AFR bases/groups would be significantly impacted by new requirement if no additional resources were provided

to the RMU. The Defense Health Agency is budgeting to fund $21M over the next 5 years to address equipment and manpower issues for the ADAF in order to effectively implement the new DoDI 6055.12 requirement. ADAF will begin assessing ARC equipment and manpower requirements in 2022 - 2023. A tactical pause on implementing DoD members with 1 day per year hazardous noise exposure into the Hearing Conservation Program is recommended and following guidance in AFI 48-127 until RMU resource needs can be evaluated and supported.

I. Other occupational exposures – specifically ototoxicity – may very well require that a TR be included in the HCP and receive annual audiograms even when they may not be working in an established hazardous noise work area. This exposure must be appropriately identified by the host installation BE flight or AFRC BE/PH office, reviewed by the OEWHG and signed off by the IOEMC.

Chapter 30
AFI 48-133, *Duty Limiting Condition*

1. References / Further Reading.

A. DAFMAN 48-108, *Physical Evaluation Board Liaison Officer (PEBLO) Functions: Pre-Disability Evaluation System (DES) and Medical Evaluation Board (MEB) Processing*

B. DAFMAN 48-123, *Medical Examinations and Standards*

C. AFMAN 36-2905, Air Force Physical *Fitness Program*

D. DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*

E. AFMAN 36-2136, *Reserve Personnel Participation*

2. Self-Assessment Communicators.

A. 48-133 - Medical Unit (Tracked by RMU with Aerospace Medicine mission)

B. 48-133 - Unit/CC (Tracked by All CCs, including RMU/CC)

3. Introduction. Duty limitations are managed in accordance with (IAW) AFI 48-133 and documented on an AF Form 469. All references to a Duty Limiting Condition (DLC) refer to an Assignment Availability Code (AAC) 31 and 37 unless otherwise noted. The Chief of Staff of the Air Force (CSAF) has directed that all Commanders be involved in the assignment of deployment limiting codes. RMUs will ensure that Commanders are aware of all medically driven Duty Limiting Conditions (DLC). This does not apply to Assignment Limitation Code (ALC)-C or non-compliance actions. AFI 48-133 describes how to communicate with Commanders the individual restrictions for Airmen due to medical reasons, throughout the Air Force.

4. Guidance.

A. Duty Limiting Conditions. All duty limiting conditions require the completion of an AF Form 469, *Duty Limiting Condition Report*, within the Aeromedical Services Information Management System (ASIMS).

i. It is the member's responsibility to obtain and provide copies of all civilian medical records to facilitate case processing. To assist with obtaining all records, it is recommended that the member be provided a DD Form 2870 or HCP ROI equivalent to fill out/submit to each of their civilian providers so that their records can be submitted to the RMU.

ii. Request for Medical Information MFR (Attachment 7) must be provided in conjunction with the clinical documentation to simplify and consolidate the information to convey diagnosis, medication, treatment plan, prognosis, and fitness restrictions. The requirement for clinical documentation is IAW DAFMAN 48-123 and this form will not take the place of the requirement.

iii. An AF Form 469 does not need to be created for a time limited condition (e.g., viral illness, gastroenteritis, etc.) unless the medical/dental condition is considered disqualifying for retention or mobility as defined in the current Medical Standards Directory (MSD) supplement to DAFMAN 48-123.

B. DD Form 2870, Release of Information. If civilian medical records are required of a service member as part of a medical readiness assessment or case processing, it is recommended that the member be provided a DD Form 2870 or HCP ROI equivalent to fill out/submit to each of their civilian providers so that their records can be submitted to the RMU.

i. The form and instructions are available via the DOD Directives Division.

C. Documentation on AF Form 469. The RMU will document the member's restriction for duty, mobility, and fitness, even when restricted from participating. Once signed and completed, the AF Form 469 will be automatically emailed to notify the unit Commander via ASIMS.

i. Any case submitted to AFRC/SGO that does not have appropriate Mobility Restriction (MR), Duty Restriction (DR) or Fitness Restriction (FR) listed on the AF Form 469 will be returned to the RMU for correction before it is sent to the Informal Physical Evaluation Board (IPEB).

D. Commander notification. ASIMS will electronically forward the AF Form 469 to the member's Commander. If a mobility restriction block is checked the Commander must concur or non-concur. If the Commander concurs, the Commander or designated representative will issue the form to the member. If the Commander non-concurs, follow procedures described in AFI 48-133. Only non-concurrence requires RMU notification. Commander non-concurrence does not require RMU to change the DLC, but does require and entry in the STR by the RMU explaining continued need for MR. Commander, non-concurrence must the reported to AFRC/SG3P at afrc.sgp@us.af.mil, and members may not deploy or otherwise enter a COCOM AOR without approval of the COCOM, even if local CC non-concurs on the MR.

E. Assignment Availability Code (AAC) 31 and 37. An AAC 31 or AAC 37 may be levied at any time when a Reserve member's medical/dental qualifications for worldwide duty are questionable, pending further evaluation. The Medical Standards Directory (MSD) identifies the more common medical/dental conditions, which require an AAC 37; however, this reference is not all-inclusive. DAFMAN 48-123 provides guidance on when an AAC 31 or AAC 37 would be applicable in general.

ii. Any permanent or temporary medical/dental condition which, in the opinion of the privileged military medical provider/dentist, may compromise an individual's health or well-being for more than 30 days, or would prejudice the best interest of the government, is sufficient cause to render an AAC 31 or AAC 37.

F. Deployable With Limitations. See AFRC/SG3P Kx, DLC-AMRO-IRILO-DES folder for most current guidance.

There are conditions that, while not medically disqualifying, may permit a Service member to deploy with some limited restrictions. Prior to the service member being tasked to deploy, Unit Deployment Managers (UDM) should contact the RMU Deployment Health staff to verify the deployment location is compatible with the service member limitations. Commanders will have more input into when and where their members can deploy. COCOM pre-deployment instructions will still need to be followed if a waiver is needed prior to deployment. These may also require that the AMRO review their case annually to determine if any changes in their condition have presented. RMUs will issue a "Duty Restriction" or "Deployable With" limitation AF Form 469 yearly, as appropriate (see MSD). Below are some common conditions, with recommended language for each, the AF Form 469 should be renewed each year during the PHA, and the DD Form 2766 updated.

i. ADHD - Members identified with ADHD are not subject to a fitness for duty evaluation, ADHD is a potentially "unsuitable" rather than an "unfitting" condition to be handled by the Commander not the RMU. When a member with ADHD presents the RMU should immediately notify the Unit/CC and advise them of the following as part of their consideration in whether to retain or separate the member:

a. Attention Deficit Hyperactivity Disorder (ADHD) is an un-suiting condition not unfitting condition which may still require duty restrictions depending on the severity of the disease, treatment, and member's AFSC. Any member with ADHD requiring stimulant medication must be referred to the commander for consideration of waiver versus administrative separation. Members should be retained in rare circumstances where benefits outweigh the risks. Careful consideration must also be given to work restrictions for those individuals in safety sensitive jobs. Consideration of work accommodations to reduce or eliminate activities which pose risk to member or fellow Airmen should be annotated on the AF Form 469. Consider the need for constant and/or high level of alertness, driving motor vehicles, operating complex machinery, handling dangerous chemicals all need to be factored into the recommendations made to the commander.

b. It is recommended that commanders who elect to retain a member with ADHD provide a MFR back to the RMU stating such for filing in the

medical record and updating of the DD Form 2766, RMU will still be required to issue a Deployable With limitation AF Form 469 on an annual basis.

c. The AF Form 469 for any member with ADHD on a stimulant should be added, *"Member is on a medication which may affect OCONUS duty. Prior to any deployment or TDY review is necessary to ensure gaining COCOM policy requirements are met."* (DW profile verbiage will be automatically added once the DW box is checked in ASIMS.)

ii. Sickle Cell Trait (SCT) – SCT is not unfitting unless members with the trait develop symptoms attributable to SCT, then a fitness for duty evaluation is required. Sickle Cell Trait generally is a benign silent medical condition not regarded as a disease unless under unusual pathologic circumstances complications occur. Serious complications include but are not limited to gross hematuria, hyphemia complications, and splenic infarction with altitude hypoxia or exercise. Additionally, sickle cell trait has been associated with life-threatening complications related to exercise, exertional heat illness (rhabdomyolysis, heatstroke, or renal failure) or idiopathic sudden death. Pathologic processes that cause hypoxia, acidosis, dehydration, hyperosmolality, and hypothermia, or elevated erythrocyte 2, 3-DPG can transform silent sickle cell trait into a syndrome which acts like sickle cell disease with vaso-occlusion due to rigid erythrocytes. Reference Chapter 9 of this document for additional information on SCT.

a. Duty Restrictions for SCT for AF Form 469: *"Member has medical condition which could limit the individual's exercise tolerance and capacity for physical exertion. This condition also predisposes them to serious or life-threatening complications. Prior to any new activities which place member at increased metabolic stress, (such as an intense exercise regimen, manual labor at altitude, etc.) member requires an acclimation plan. Ensure adequate hydration."*

iii. Pseudo Cholinesterase Deficiency - is an inherited enzyme abnormality that results in abnormally slow metabolic degradation of exogenous ester drugs such as succinylcholine and mivacurium. Generally, this is a silent condition except in the certain settings such as general anesthesia. The deficiency in plasma activity leads to prolonged muscular paralysis resulting in extended need for mechanical ventilation. Treatment is continuation of mechanical ventilator support until diffusion of succinylcholine from the myoneural junction permits return of neuromuscular function of skeletal muscle to avoid hypoxia and potentially death from respiratory arrest. The deficiency also can increase the risk of systemic toxicity produced by ester-type local anesthetics.

a. The member's DD Form 2766 will be annotated, and member will be issued Red allergy dog tag to alert providers to possibility of needing prolonged ventilator support.

b. An additional concern for service members with this disease is the noncompetitive cholinesterase inhibitors (organophosphate insecticides, nerve agents) and competitive cholinesterase inhibitors (neostigmine, physostigmine) as there are case reports of prolonged apnea and paralysis, incomplete antagonism, and potentiation of blockade particularly in setting of concomitant use of succinylcholine use.

c. Members need to be counseled with respect to their increased risk when being issued anti-nerve agent antidotes. Consideration should be given to avoidance physostigmine aka P-tabs.

d. Duty Restrictions for Pseudo cholinesterase Deficiency for AF Form 469: *"Member has a medical condition which may affect OCONUS duty specifically if nerve agent antidotes and/or P-tabs are warranted. Prior to any deployment or TDY, review and coordination is required."*

iv. G6PD deficiency - All service members initially identified with a G6PD deficiency require medical education in a face-to-face visit documented in the medical record and renew annually during the PHA.

a. Members found to be G6PD deficient will be placed on a P-2 profile with the following statement placed in the remarks section of an AF Form 422, Notification of Air Force Member's Qualification Status, and *"Member has a medical condition which may affect OCONUS duty if terminal malaria prophylaxis is warranted."*

b. The member's Unit Commander, Wing Flight Surgeon and CINC should be involved in any deployment decision where malaria prophylaxis is specifically required."

c. Duty Restriction for G6PD deficiency is also require on an AF Form 469: *"Member has a medical condition which may affect OCONUS duty specifically if terminal malaria prophylaxis is warranted. Prior to any deployment or TDY, review and coordination is required."*

G. Pseudo Folliculitis Barbae (PFB). See AFRC/SG3P Kx, DLC-AMRO-IRILO-DES folder for most current guidance. Shaving waivers will remain valid for 5 years from the date of issuance. The Aeromedical Services Information Management System (ASIMS) is not currently able to accommodate 5-year profiles. No changes have been made to the AF Form 469/profile process, the AF Form 422/clearance process, or to the Aeromedical Services Information Management System (ASIMS). Changes to ASIMS to accommodate a 5-year profile would create significant negative impact on the Integrated Disability

Evaluation System (IDES). The AF Form 422/medical clearance is changing in connection to an approved medical clearance process (random AF Form 422s will no longer be permitted). Further collaboration is needed between stakeholders to assure a cohesive and efficient process is developed to support 5-year shaving waivers for service members (SMs) with an active diagnosis of PFB or other qualifying diagnosis. No interim changes will be made to the AF Form 469/profile process, AF Form 422/medical clearance process, or ASIMS as the second/third order effects of proposed changes must first be fully investigated.

AF Form 469/profiles entered in ASIMS will not show as active after 12 months, however the records will remain accessible. If the initiation date of the most recent shaving waiver for PFB is within the past 5 years, the inactive record in ASIMS will meet the requirement set forth in the AF/SG's memorandum. The AF Form 422 for medical clearance is designed to show medical qualifications as a communication tool between the AFMS and AFPC (refer to AFI 10-203 soon to be AFI 48-203). Shaving waivers should not be entered onto this form. Further, the Airman Availability Management (AAM) program is driving changes to the AF Form 422/medical clearance process. These changes in ASIMS will prevent generation of an AF Form 422 for purposes of a shaving waiver.

SMs should keep a copy (printed or electronic) of the AF/SG memo and an appropriately dated AF Form 469. Historic AF Form 469/422 are not available in MyIMR for SMs to print independently. Every 5 years, the SM will need to be re-assessed by their primary care provider or a dermatologist to have the AF Form 469 renewed, until a new process is approved conforming to AFIs 44-102 and 36-2903.

H. AAC to DAV Code Conversion. AAC's 31, 37, and 81 and ALC's X (C1), Y (C2), and C (C3) automatically generate associated Duty Availability (DAV) codes within MilPDS. The converted DAV codes are:

i. AAC 31 = DAV 41

ii. AAC 37 = DAV 42

iii. AAC 81 = DAV 49

iv. ALC-X and DW = DAV 40

v. ALC-Y = DAV 43

vi. ALC-C = DAV 48

I. Light Duty Profiles. Effective May 2019, all Mobility Restricting Profiles (AAC 31) on the AF Form 469, with duration of 90 days or less, will automatically include the following language in the Physical Limitations/Restrictions section: "*Airman has a Light Duty, Mobility Limiting Condition that is expected to resolve in 30 days, extendable up to*

90 days." These Airmen will be classified "*Deployable*" IAW DoDI 1332.45, *Retention Determinations for Non-Deployable Service Members*.

i. RMUs should not change their profiling practices; they should continue to apply the type and duration of profiles appropriate to the Service member's medical condition and operational situation. The light duty verbiage will be added by ASIMS and should not need to be manually entered into the AF Form 469 remarks.

ii. While AAC 31s of a duration of 90 days or less will still show as Red for IMR reporting, they will not be considered non-deployable when deployability metrics are reported to Under Secretary of Defense, Personnel and Readiness (USD[P&R]).

J. Fitness Restrictions (FR) and Fitness Assessment Exemptions (FAE). The AF Form 469 will be used to remove a member from components of the Fitness Assessment. Member will submit a DD Form 2870 or HCP equivalent to each civilian healthcare provider so that documentation can be sent to the RMU. Request for Medical Information MFR (Attachment 7) may be filled out by each of the member's civilian healthcare provider indicating their diagnosis, treatment plan w/ current medications, prognosis, as well as recommendations related to fitness, duty restriction, and duration of the limitations. The military RMU provider will review civilian documentation and determine all appropriate restrictions to include fitness and document such on the AF Form 469 IAW AFMAN 36-2905. The privileged military medical provider must interpret, assess, and determine the appropriate restrictions. The privileged military medical provider may modify or override recommendations or restrictions following evaluation when exercising their best judgement IAW AFI 48-133.

i. The AF Form 469 will NOT be issued to Reservists for fitness assessment exemptions and fitness restrictions not on EAD without supporting documentation and Request for Medical Information MFR (Attachment 7) from the member's civilian healthcare provider.

ii. A unit Commander may allow members to become non-current if there is a concern about testing them prior to receipt of supporting clinical documentation. See AFMAN 36-2905 for further guidance.

iii. At every encounter, privileged military medical providers must determine the member's duty, fitness, and mobility requirements within their Air Force Specialty Code (AFSC), office, grade, rank, rating, and whether a member can meet all physical standards associated with being deployed or in garrison IAW DAFMAN 48-123 and DoDI 6490.07 when recommending any restrictions. (DR, FR, or Mobility Restriction [MR])

iv. FAE and FR will be documented using the default templates within ASIMS for service-wide uniformity and consistency.

v. Members who are dependents and seen in the MTF may not be dispositioned for Reserve duty and placed on a Duty Limiting Condition Report by the MTF provider. AFR RMUs retain all authority with regards to clearance or restrictions from military duty. MTFs may provide recommendations via documented encounters in the EHR. All Traditional Reservist will be dispositioned by their assigned privileged military medical provider assigned to their respective RMU.

Note: *FR should almost always have an accompanying DR even if the member works in a primarily administrative position. There will be rare instances when a FR will not have an accompanying duty restriction. For example, if the provider feels that member cannot perform a push-up, a duty restriction of no push/pull greater than 20 pounds should first be addressed. This will provide the member's Commander with a clear understanding of the member's limitations in garrison beyond simple FR.* ***There will always be a correlation between not being able to perform AF Fitness test components and functional duty restrictions.***

K. Recurring Fitness Restrictions. While members may require permanent/recurring FR/FAE, IAW AFI 48-133 an AF Form 469 may NOT be issued for more than 365 days, therefore the AF Form 469 must be reviewed and renewed annually by the AMRO only. An update to the member's STR will be made, annotating the AMRO findings.

i. Members requiring a FR/FAE exemption for more than 12 months which obviously includes those of a permanent nature must be reviewed by the AMRO to determine if member meets retention and deployment medical standards. If the AMRO determines that the member meets retention/deployment medical standards despite the FR/FAE restrictions, the AF Form 469 can be issued for 365 days.

ii. Annually, member will submit a DD Form 2870 or HCP equivalent to each civilian healthcare provider so that documentation can be sent to the RMU as well as the Request for Medical Information MFR (Attachment 7). It is important to explain to members that receive a recurring Duty Limiting Condition Report, that it is not "permanent." An annual AMRO review must still be conducted to determine that the condition(s) have remained stable and not worsened to the point that mobility or additional duty restrictions are now warranted or that they now do not meet retention standards.

L. Airmen Medical Readiness Optimization (AMRO). Reserve Medical Unit (RMU) will generate a monthly AMRO board report in ASIMS to track and update the status of each member on an AAC, ALC, and FR/FAE. A medical records entry is highly encouraged for accountability purposes, made each month to validate status review and update of a member's AAC. Additionally, a monthly briefing should be given to the Wing CC, Group CC and Unit CC in order to establish situational awareness of all members on AAC. The AMRO is also responsible for reviewing all cases referred for appropriate trigger events discussed in DAFMAN 48-133, validating Deployable With

limitations (DW) AF Form 469s, and reviewing IRILO cases for quality prior to submitting to AFRC/SGO for disposition.

M. Deployment Availability Working Group (DAWG). The DAWG still exists for oversight of the AMRO boards and to monitor and report metrics to the Aerospace Medicine Council (AMC).

The DAWG will collect and report Diagnosis and Medication Surveillance quarterly to AMC. This surveillance is different for the AFR RMU as a non-care rendering entity, than for ADMTF. The intent/purpose of this requirement is the same though to *"ensure Airmen with certain medical conditions do not remain unidentified in the mobility reporting system"*. So, by default it is designed to report on members that did not get placed on DLC and thus would not show up on an AMRO report but maybe should have. At its core this is a query of certain DX and medications and a QC of these on a quarterly basis to ascertain if the DLC actions occurred correctly. On AD they likely query the EHR and cross references against ASIMS. Recommended execution in an RMU to meet the intent of this requirement is as follows:

i. Per SGP what conditions or medications they want to focus on for a given quarter.

ii. The technician RR in support of primarily PHAs, but really for any instance that a technician must accomplish a RR would need to log those instances that DX or medication were noted in the RR.

iii. At end of the quarter the MSME would use that report as the basis for their review with SGP compared to the DLC decision made, if error was made (DLC action or at least an AMRO referral should have been considered) use refer to ARMO.

iv. Record and report to the DAWG and in turn to to AMC and EMC

v. SGH briefs results to professional staff annually, (in theory would have 4 unique reports to go over).

vi. Report to DAWG would be something along the lines of;
For the reporting period of XXXX, A) 25 cases with XXX DX were not referred to the AMRO Board; B) of these 25, review shows that XX did not require referral and decision to not refer was in line with standards, C) XX of the 25 should have been referred and were not in line with standards and D) The common missed application of standards or other errors that contributed to the referral not occurring that should have are XXX.

vii. SGH could then use the lessons from this quarterly review to prepare annual professional staff training.

N. Notification to Military Personnel Flight. Reserve Medical Unit (RMU) will notify the MPF by providing the Reconciliation Roster of members on AAC 31, AAC 37 and AAC 81 monthly. This is done by generating an AMRO report in ASIMS. No PII or HIPAA information should be included in the AMRO report sent to the MPF POC.

i. The MPF POC will update Duty Status Codes (DSC) accordingly. Upon receipt of an appointment letter the POC may be added to the AF Form 469 or AF Form 422, *Profile Serial Report*, POC email within ASIMS to ensure they receive a copy of all profile actions so that DSC can be updated on an ongoing basis.

ii. The "Physical Limitations/Restrictions" block on AF Form 469 will contain the following statement when a member is placed on a Mobility Restriction (MR), AAC 31 or AAC 37: "For MPF: Update Duty Status code (DS) "14".

O. Pregnancy Restrictions. See AFI 44-102 for profiling restrictions on pregnant personnel. Participation during pregnancy is governed by AFMAN 36-2136.

P. Post-Partum DLC Actions.

i. Remove the AAC 81 immediately upon being notified of completion of pregnancy as they are no longer pregnant.

ii. Issue Duty and Fitness Restrictions appropriate through the recovery phase.

iii. Following recovery phases, annotate fitness restrictions, but do not exempt a specific element (1.5-mile run, 2 KM walk, push up, sit-ups, waist measurement). Instead, include the following statement *"Member is excused from Fitness Assessment until [DATE*]. *This does not preclude participation in unit or individual fitness programs."*

a. "DATE" for this FR will be 1 year (365 days) after discharge IAW AFMAN 36-2905.

Q. Transgender Health Medical Evaluation Unit to Initiate/Update Medical Profiles.

i. DoDI 1300.28 In-Service Transition for Transgender Service Members – implementation guidance for profiling process.

a. Gender Dysphoria diagnosis by civilian provider is reviewed by local military provider at MTF or RMU.

b. Local military provider enters AAC 31 into ASIMS for SM (Gender Dysphoria is no longer disqualifying for retention standards per MSD but

Code 31 facilitates stability in place for SM during medical transition period).

c. Local military provider accomplishes THMEU referral process for SM IAW policy & guidance by utilizing the "Templates" resources found on the Transgender Care Kx site.

d. Once THMEU process and DX validation/confirmation is complete the THMEU staff sends an AMRO review request to SM's local referring MTF or RMU MSME.

Note: *POCs ORG Box & phone numbers for Transgender Care at the THMEU office can be found on the Transgender Care Kx site by clicking on "THEMU" button.*

R. Initial Review In Lieu Of (IRILO) Medical Evaluation Board (MEB). An IRILO must be completed in the Electronic Case Tracking (ECT) system. When processing a Non-Duty Disability Evaluation System (NDDES) case, RMUs may proceed directly to full case processing without first completing an IRILO if the AMRO determines the case is likely to be medically disqualified by AFRC/SGO. If the AMRO review finds members are a good candidate to be RTD the IRILO should be submitted versus a Non-Duty Disability Evaluation System (NDDES). See Chapter 39 for guidance.

S. Non-Duty Disability Evaluation System (NDDES) processing. When a member is placed on an AAC 37 for a non-duty related processing, see Chapter 39 for guidance.

T. Medical Serial Profile (PULHES) on Return to Duty (RTD). Following RTD after an IRILO, NDDES or MEB, the servicing RMU must update the PULHES, which is divided by Physical Condition, Upper Extremities, Lower Extremities, Hearing (Ears), Vision (Eyes), and Psychiatric Stability. While often forgotten since the AF Form 469 came into use, the PULHES and AF Form 422 still fill a crucial mission requirement and must be updated correctly and accurately.

i. USAF Medical Standards Directory (MSD), Section R establishes the medical standards for proper assignment of the Medical Serial Profile.

ii. Following return to duty and placement on an ALC, RMUs must accurately update the appropriate section of the PULHES commensurate with the condition realizing a "1" will never be appropriate for someone whose condition is severe enough to warrant any fitness for duty case (I-RILO, MEB, or NDDES). Therefore, the gray area will be between '2" and "3", and the ALC stratification assigned is a good indication of what PUHLES rating is most appropriate for the member.

iii. C1 = Mild conditions

iv. C2 = Moderate

v. C3 = Severe

vi. Review DAFMAN 48-108 for more specifics. Taking the definitions of each ALC and comparing them against the PULHES standards within MSD, Section R will help guide the most appropriate PULHES.

U. Profile Modifications. A Profile Modification is used after a RTD case has been completed and member has been placed on an ALC (X, Y, or C, also known as C1, C2 or C3, respectively). The Report of Medical Evaluation (RME) memorandum returns a member to duty and provides specific restrictions listed within the document that will be placed on the AF Form 469 and AF Form 422, respectively. C1 and C2 are in line with what is noted in DAFMAN 48-108. Requests for members to deploy while on a C1 or C2 are a sub-type of the profile Modification (MO) and are the most common; as such deployment waivers have their own process and workflow in ECT. Any case requiring another MAJCOM/SG office to approve must be routed via ECT to AFRC/SGO as a Deployment Waiver (DW).

i. The Profile Modification (MO) workflow is used for members on an ALC-C3. The return to duty of members on an ALC-C3 results in restriction to Unit Training Assemblies (UTA) and Annual Training (AT) at home station only. This is a restriction not specifically outlined or addressed in DAFMAN 48-108 as it is Reserve specific. For this reason, an ALC-C3 requesting anything outside of UTA and AT at home station only can be considered and thus waived by AFRC/SGO and requests for such action should be submitted via the ECT "Modification" (MO) queue. Do not submit a Profile Modification (MO) for an un-adjudicated case.

a. MO requests may be made in no more than 3 month increments and may combine multiple requests for periods of duty outside of UTA and AT at home station.

b. For example, if a SM will potentially need to be cleared for two or three separate TDYs over a 3-month period the RMU may submit one MO request detailing each TDY/period of duty that will take place within the 3-month period.

V. Management of Expired ALC. Members with expired ALCs are medically disqualified for continued military duty. Members who have not complied with submitting necessary documentation by submitting a DD Form 2870 or HCP ROI equivalent to each civilian healthcare provider so that documentation can be sent to the RMU to renew the ALC/Retention Waiver will be referred to their Commanders IAW DAFMAN 48-123. If the member has complied with the RMU's requests for appropriate medical documentation, and the overdue ALC is no fault of the member's: A new AF Form 469 will be issued (with no change to the AAC) and will indicate the expired ALC,

with the member restricted to UTA and AT at home station only, while the renewal case is submitted and adjudicated to AFRC/SGO.

ii. If the member HAS NOT complied with submitting a DD Form 2870 or HCP ROI equivalent to each civilian healthcare provider so that documentation can be sent to the RMU in a timely manner (see DAFMAN 48-123), the member will be placed in non-compliance status following the actions detailed below:

a. Generate the Non-Compliance MFR (Attachment 9) and send to member's commander and the MPF to update the DS code.
b. Place the MFR in the member's medical record and/or upload to EHR.
c. The RMU will update the current AF Form 469 adding the following statements to the top of the REMARKS section; "Member's ALC Retention waiver has expired, notification of member non-compliance sent to CC and FSS on (date), IAW DAFMAN 48-123."

d. The member will not be released from non-compliance status until the RMU has received the necessary records to process the ALC Renewal case. Once the member submits required documents the RMU will issue the release from non-compliance memo (Attachment 10).

X. Member Non-Compliance on AAC. Members who are already on an AAC 31, 37, or 81 and are non-compliant with submitting a DD Form 2870 or HCP ROI equivalent to each civilian healthcare provider so that documentation can be sent to the RMU, will be referred to their Commanders via Non-Compliance letter.

iii. A member with a known, unknown, or questionable medical or dental condition who refuses to comply with a request for medical information or evaluation is considered medically disqualified for continued military duty and the RMU will follow the actions detailed below:

e. Generate the Non-Compliance MFR (Attachment 9) and send to member's commander and the MPF to update the DS code.

f. Place the MFR in the member's medical record and/or upload to EHR.

g. The RMU will use the following statement at the top of the remarks section in the MFR: "Member has failed to provide the necessary medical records to either release them from their AAC or continuing processing their fitness for duty evaluation and should be treated as non-compliant IAW DAFMAN 48-123."

h. The member will not be released from non-compliance status (Attachment 10) until the RMU has received the necessary records to further evaluate the condition and/or process the required fitness for duty evaluation.

i. The applicable AAC will be continued in ASIMS until such time as the RMU can either verify resolution of a temporary limiting condition (AAC 31 or 81) or process the fitness for duty evaluation with a resulting return to duty determination in the case of a AAC 37. Entries in the AMRO records should reflect the deferral of the case to the unit/CC for action.

Y. **Non-Compliance for Documentation Request.** Members who have failed/refused to provide clinical/medical treatment records when not yet on an AAC 31 will be referred to their Commanders IAW DAFMAN 48-123.

iv. A member with a known, unknown, or questionable medical or dental condition who fails/refuses to comply with a request for medical information or evaluation is considered mobility restricted and will be placed on an AAC 31 to reflect such. The RMU will follow the actions detailed below in addition to generating the AF Form 469 with the AAC 31:

j. Absent records to the contrary the RMU should presume worst case scenario and err on the side of caution and apply stringent duty and fitness restrictions to the AF Form 469.

k. Generate the Non-Compliance MFR (Attachment 9) and send to member's commander and the MPF to update the DS code.

l. Place the MFR in the member's medical record and/or upload to EHR.

m. The RMU will use the following statement at the top of the remarks section of the MFR: "Member has failed to provide the necessary medical records and therefore is not medically qualified for continued military service and should be treated as non-compliant IAW DAFMAN 48-123"

n. The AAC 31 will be continued in ASIMS until such time as the RMU can either verify resolution of the limiting condition or determine an I-RILO and conversion of the AAC to 37 is warranted. Entries in the AMRO minutes should reflect the deferral of the case to the Unit/CC for action until either of these have occurred.

Z. **No Show for Medical/Dental Appointments for Fitness for Duty Evaluations.** AFRC members who fail to show for medical/dental appointments related to processing their fitness for duty evaluation case are non-compliant and will be referred to their Commanders for processing IAW DAFMAN 48-123.

v. A member who fails to show for required appointments necessary to process a fitness for duty evaluation case is considered non-compliant and the RMU will the follow the actions detailed below:

o. Generate the Non-Compliance MFR (Attachment 9) and send to member's commander and the MPF to update the DSC.

p. Place the MFR in the member's medical record and/or upload to EHR.

q. The RMU will use the following statement at the top of the remarks section in the MFR: "Member has failed to show for required medical/dental appointment and therefore is not medically qualified for continued military service and should be treated as non-compliant and consider for administrative separation by the commander IAW DAFMAN 48-123."

r. The member will not be released from non-compliance status (Attachment 10) until they report for the required evaluation and the required fitness for duty evaluation can be processed.

s. The applicable AAC will be continued in ASIMS until such time as the RMU can either verify resolution of a temporary limiting condition (AAC 31) or process the fitness for duty evaluation with a resulting return to duty determination in the case of an AAC 37. Entries in the AMRO records should reflect the deferral of the case to the unit/CC for action.

Note: *The phrase **"fitness for duty evaluation"** is an all-encompassing blanket term that includes the I-RILO, MEB/IDES, and Non-Duty Related Disability Evaluation (NDDES) cases/process. This term also includes local RMU provider reviews/determinations to issue, remove, or adjust duty/mobility restrictions or to refer members into anyone of the three more formal case processes previously mentioned.*

Chapter 31
AFI 48-137, *Respiratory Protection Program*

1. References / Further Reading.

A. AFI 10-403, *Deployment Planning and Execution*

B. AFI 48-145, *Occupational and Environmental Health Program*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This Instruction implements the Department of Labor, Occupational Safety and Health Administration (OSHA) standard Title 29, Code of Federal Regulations (CFR), Part 1910.134, Respiratory Protection, and National Fire Protection Agency (NFPA) 1852, Standard on Selection, Care, and Maintenance of Open-Circuit Self-Contained Breathing Apparatus (SCBA), current editions as authorized under DODI 6055.05 Occupational and Environmental Health, DODI 6055.1 DoD Safety and Occupational Health Program, DODD 4715.1E, Environment, Safety, and Occupational Health. This Instruction applies to all Air Force (AF) installation Commanders, all AF military, and civilian personnel (including Air Force Reserve Command (AFRC) and Air National Guard (ANG) units and members).

4. Guidance. When Public Health (PH) or Occupational Medical Service (OMS) for AFRC units with BE/PH positions are at collocated installations (i.e., AD is the host and AFRC units are the tenants), the OMS is responsible for TR personnel and shall be completed by the ground RMU and for Civilian Federal Employees, including Air Reserve Technicians, by the active-duty host military treatment facility or equivalent. At stand-alone AFRC installations, the OMS is responsible for TR personnel and shall be completed by the ground RMU and for Civilian Federal Employees, including Air Reserve Technicians, by the AFRC full-time BE/PH Office.

A. Intent. To ensure that required administration of medical records or an interface with civilian personnel and are not expected to be part of the BE/PH office responsibilities.

B. Chain of Events. For an initial respiratory protection Medical Surveillance Examination (MSE) at an AFRC installation:

i. BE/PH office health risk assessment identifies an exposure profile during the industrial shop survey for a process which would require respiratory protection.

ii. The OEWHG, working with the BE/PH office (as the installation authority for determining if respiratory protection is required) identifies the individuals assigned to the exposed SEG (PEG) be placed on the RP program.

iii. The shop is notified that the personnel in the exposure group are on the RP program, and the required MSE components are presented with the notification.

iv. DOD civilians (to include ART staff) are provided the OSHA RP questionnaire (either by the shop supervisor, Civilian Personnel office, RMU staff, Contract OH provider, or BE/PH office). The determination of who is providing the MSE paperwork packets should be defined by how the MSE process will work best for the individual getting the MSE and the unit in general. The unit should consolidate the number of steps necessary to complete the medical requirements for the civilian employees.

v. Individual completes the questionnaire and presents it to the physician or other licensed health care provider (PLHCP) for review and approval to wear the respiratory protection necessary to accomplish the process. A copy of 29 CFR 1910.134 (e)(5)(i)(A-E) and chapter 5 of 48-137 in addition to the workplace specific RP program is available for the evaluating PLHCP to review (excerpted from AFI 48-137, para 5.2.3.).

vi. If the individual gets the go-ahead to wear the respirator, they return the completed questionnaire to the RMU to be filed in their civilian medical record (or use the unit established mechanism to ensure that the appropriate documents are properly filed in their medical record).

vii. The RMU makes a copy of the signature/approval page and sends individual and copied approval to BE/PH office for fit testing in the approved respirator, or the RMU updates ASIMS Web OH module to reflect completion of the qualifying MSE, and after the BE/PH office checks in the ASIMS Web Occupational Health Module to ensure medical clearance to wear the respirator (is complete), then conducts the fit test and documents the fit test in DOEHRS IH.

viii. Prior to the required annual fit test (29 CFR 1910.134(f) (2)) and training, if an individual is being fit tested, or there is some other change in the workplace, the BE/PH office must have the individual review the questions regarding medical/physical changes. Use of questions 1-15 from the OSHA questionnaire is recommended, but OSHA's letter of interpretation indicates the individual "only" needs to answer questions 1-8, which could affect respiratory wear.

ix. If there is a "yes" response, the individual is referred to the PLHCP with a complete OSHA questionnaire, and the additional required documentation for an appropriate medical evaluation.

x. If individual indicates all responses are "no," then BE/PH proceeds with the fit test (recording the results in DOEHRS IH). It may be beneficial for personnel to sign a log indicating that they have reviewed the questions, and that all responses are indeed "no."

xi. For clarity, AFI 48-137, para 5.2.1., is reproduced here: "The medical evaluation consists, at a minimum, of completing the respirator medical evaluation questionnaire for PLHCP review and is only an initial requirement. There is no

requirement to re-accomplish respirator medical evaluation questionnaires annually, however, medical evaluation will need to be redone under certain circumstances (e.g., job duty change, respiratory protection changes, relocation to a new duty location, etc.) as determined by BE. At a minimum, the mandatory questions stated in the 29 CFR 1910.134, Appendix C, will be used. In addition to the mandatory questions, OSHA's optional questions and other questions developed locally may be used. The current respiratory questionnaire must be filed in the individual's medical record."

xii. Additional medical evaluations. At a minimum, the employer shall provide additional medical evaluations that comply with the requirements of this section if:

a. An employee reports medical signs or symptoms that are related to ability to use a respirator (29 CFR 1910.134(e) (7) (i)).

b. A PLHCP, supervisor, or the respirator program administrator informs the employer that an employee needs to be reevaluated (29 CFR 1910.134(e) (7) (ii)).

c. Information from the respiratory protection program, including observations made during fit testing and program evaluation, indicates a need for employee reevaluation (29 CFR 1910.134(e)(7) (iii)).

d. A change occurs in workplace conditions (e.g., physical work effort, protective clothing, temperature) that may result in a substantial increase in the physiological burden placed on an employee (29 CFR 1910.134(e) (7) (iv)).

Chapter 32
AFI 48-139, *Laser and Optical Radiation Protection Program*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

B. AFI 48-101, *Aerospace Medicine Operations*

C. DAFMAN 48-123, *Medical Examinations and Standards*

D. AFI 48-145, *Occupational and Environmental Health Program*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. The basic elements of the program emulate those of American National Standards Institute (ANSI) Z136.1, American National Standard for Safe Use of Lasers, and any other standard in the ANSI Z136 series, as applicable. This instruction applies to all Air Force (AF) personnel, AF Reserves, Air National Guard, direct reporting units (DRU) and field operating agencies (FOA).

4. Guidance. See AFI for further guidance. AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 33
AFI 48-144, *Drinking Water Surveillance Program*

1. References / Further Reading. None are applicable currently.

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This instruction applies to AF, Air National Guard and AF Reserve installations and all responsibilities herein are conferred to the host, and responsibility shall not be delegated or otherwise assigned to tenant organizations.

4. Guidance. See AFI for further guidance. AFRC/SG3P has no further policy/guidance regarding this AFI currently.

Chapter 34
AFI 48-145, *Occupational and Environmental Health Program*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

B. AFI 44-119, *Medical Quality Operations*

C. AFI 48-101, *Aerospace Medicine Enterprise*

D. AFMAN 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*

E. DAFMAN 48-123, *Medical Examination and Standards*

F. AFI 48-144, *Drinking Water Surveillance Program*

G. DODI 6055.12, *Hearing Conservation Program*

2. Self-Assessment Communicators.

A. Public Health Occupational and Environmental Health (AFRC installations BE/PH office completes the SAC with input from RMU with Aerospace Medicine mission.)

3. Introduction. This AFI establishes procedures consistent with the guidance in AFI 91-202, The US Air Force Mishap Prevention Program, for medical support requirements. This publication applies to all Air Force (AF) active-duty personnel, civilian employees, Air Force Reserve Command (AFRC) Units and the Air National Guard (ANG).

4. Guidance.

A. Medical Surveillance Examinations. Occupational Examinations will be accomplished in sync with the PHA to the greatest extent possible. The occupational examination requirements will be determined by the Occupational and Environmental Health Working Group (OEHWG), IAW AFI 48-145. To prevent unnecessary examinations, the OEHWG will use the guidance in DoDD 6055.5-M, Occupational Health Surveillance Manual, to determine appropriate medical surveillance.

B. Firefighters. New fire fighter physical examination requirement can be found at the Occupational Medicine KX.

i. This site contains the AF/SGO policy letter, Technical Implementation Guide 1582-03, health history, and a snapshot spreadsheet of examination requirements. For IRR personnel returning to Air Force Reserve status as a Firefighter, it is the

responsibility of the RMU to accomplish any required NFPA exams not otherwise documented to ensure personnel meet AFSC requirements.

C. Air Reserve Technicians (ART). Personnel receiving Hearing Conservation exams will be entered into Defense Occupational and Environmental Health Readiness System-Hearing Conservation (DOEHRS-HC) as civilians.

i. This category will be used in lieu of military since their primary exposure to hazardous noise occurs during performance of their civilian job.

ii. Unit Reservists do not require periodic annual audiograms unless indicated medically or by engineering noise survey.

a. In most circumstances Reservists that have incidental exposure to hazardous noise that does not exceed routine annual UTA days (i.e., >30 days) need not be tested.

b. Recommend that Fire Fighters (i.e., TR, ART, and Title V Civilian Federal Employees), RCSMs, and CFE with impact noise exposure (i.e., Combat Arms Training & Maintenance [CATM] and Explosive Ordnance Disposal [EOD] personnel) receive initial, annual, and termination hearing tests regardless of the 30-day rule.

c. The 30-day rule does not apply to Air Reserve Technicians whose hazardous noise exposure requiring placement on the Hearing Conservation Program is due to exposure occurring during the work week and not during Unit Training Assemblies and Annual Tour while in TR status.

d. The 30-day rule does not apply to Title V CFE (i.e. those CFE who are not ARTs).

D. Hepatitis B. All service members are required to be immunized against Hepatitis B virus (HBV). AFI 44-108, Infection Prevention and Control Program provides guidance on management of the Medical Employee Health Program (MEHP) and the Hepatitis B virus (HBV) immunization requirement.

E. Pregnancy.

i. Military Evaluation. The pregnant member presents documentation from her private obstetric care provider to her supporting RMU every 60 days. The RMU physician examines the member and completes an AF Form 469. The RMU physician then refers the pregnant member to the RMU, AFR BE/PH Shop or ADMTF public health (PH) technician for a medical pregnancy interview and education. In the absence of a PH technician, the medical interview and education is accomplished by an Aerospace Medical Service Technician (4N0X1/4N0X1F)

or nurse corps officer in consultation with the servicing Bioenvironmental Engineering section.

ii. **Pregnancy Interview.** The interview includes the briefing statement and the supervisor's letter. The interviewer signs both documents and the member will sign the briefing statement. File the original briefing statement in the member's medical record and give a copy to the member. The letter to the supervisor is given to the member to pass on to her commander or supervisor.

a. If the interview indicates that the pregnant member does not work in a potentially hazardous environment (for example, industrial workplace) the interviewer annotates the Standard Form 513, Medical Record-Consultation Sheet, and gives it, the briefing statement, and commander's letter to the RMU physician. The physician reviews all information, documents appropriate comments on the SF 513, and gives the briefing statement and commander's letter to the member if she is found medically qualified for continued participation.

b. If the interview indicates that a potentially hazardous situation exists, the RMU full time staff requests an evaluation of the pregnant member's work area by the active-duty PH office (for collocated units) or Aeromedical Medical Services Technician (4N0X1) or nurse corps officer in consultation with the servicing Bioenvironmental Engineer (for non-collocated units) and provides a copy of the AF Form 469, and SF Form 513. Use AFRC Form 20, Pregnancy Workplace Evaluation, to record the results of the work area evaluation.

iii. **Non-collocated Bases.** On non-collocated bases, the assigned bioenvironmental engineering or PH personnel conducts the required interview and workplace evaluation. The medical commander may also assign an aerospace medical service technician (4N0X1) or nurse corps officer to conduct the interview and workplace evaluation in consultation with servicing bioenvironmental engineering.

iv. **Military Physician.** Upon receipt of the completed package (AFRC Form 20, SF Form 513, AF Form 469, briefing statement, and the member's job description obtained from the member's supervisor by the active-duty PH office), the military physician documents any additional restrictions on the AF Form 469 and gives the member a copy of the briefing statement and the supervisor' letter. The completed package is filed in the member's medical record.

v. **Medical Squadron.** Each medical unit sets up a suspense file to ensure pregnant members are adequately monitored and periodic progress reports from the member's civilian health care provider are received tracked via the AMRO. Periodic progress reports detailing any special medical problems, complications, restrictions, etc. are provided to the medical unit at least every 60 days.

Individuals who do not submit required progress reports should be restricted from Reserve participation.

vi. **Profile Officer.** The designated profile officer in the medical unit monitors all pregnancy profiles utilizing AF Form 469 IAW AFI 48-133, Duty Limiting Conditions.

a. The estimated date of delivery and medical recommendations concerning specific physical restrictions are included on AF Form 469 under "Physical Limitations/Restrictions." Administrative instructions and other comments from the military physician may be recorded in this section. The Mobility Restriction box will be checked.

b. Member should be verbally advised of all necessary restrictions and a note included in the medical record that the member was advised. Advise member to carry the AF Form 469 on their person when participating in Reserve training activities.

vii. **Return to Duty.** After delivery, the member may return to full duty once cleared by their obstetric care provider. The member will provide the medical unit with a statement from her civilian obstetric care provider indicating her current health and any physical restrictions. The military physician reviews the letter and determines if the member's profile will be revised to what it previously was or if other action is appropriate. If the member had medical complications from her pregnancy, the member's supporting RMU takes the appropriate action to determine the member's medical qualifications for continued military duty according to DAFMAN 48-123.

viii. **Failure to Comply.** The medical units will manage members who fail to return to the RMU 180 days after the date of delivery. They are referred to their commanders in writing IAW AFMAN 36-2136.

Chapter 35
AFMAN 48-149, *Flight and Operational Medicine Program (FOMP)*

1. References / Further Reading.

A. AFI 48-133, *Duty Limiting Conditions*

B. AFMAN 11-402, Chapter 3, *Aviation and Parachutist Service, Aeronautical Ratings and Aviation Badges*

C. AFI 40-101, *Health Promotions*

D. AFI 44-102, *Medical Care Management*

E. AFI 48-170, *Preventive Health Assessment*

F. AFI 44-172, *Mental Health*

G. AFI 48-101, *Aerospace Medicine Operations*

H. DAFMAN 48-123, Chapter 6, *Medical Examinations and Standards*

I. AFI 48-145, Chapter 2, *Occupational and Environmental Health Program*

J. AFMAN 48-146, *Occupational and Environmental Health Program Management*

K. AFOSHSTD 48-20, *Hearing Conservation Program*

2. Self-Assessment Communicators.

A. 48-149, Flight and Operation Medicine Program (Tracked by RMU with Aerospace Medicine mission)

3. Introduction.

A. This regulation is a composite of many other Aerospace Medicine guidance and is intertwined with Occupational Health. Few standards exist only in AFMAN 48-149 that are not duplicated or reinforced in other regulations, primarily DAFMAN 48-123 and AFMAN 48-146.

B. The purpose of this regulation is to bind all these processes together, to compile the majority of the Flight Medicine and Occupational Health clinics' programs.

C. For a newcomer to Flight Medicine, this Air Force Manual should be among the first read. It provides a good introduction and foundation to many programs, whereas other AFI's would provide the deeper technical requirements of individual programs. This TIG

will not address the many programs and functions noted above; only AFRC-specific guidance is provided below. As stated in the introduction, you should always read and reference the parent AFI first and use this TIG as a supplement.

D. You can access the AFMRA Flight and Operational Medicine Clinic (FOMC) Kx for further information.

4. Guidance.

A. Fatigue Countermeasures Program.

i. Operational use of GO and NO-GO pills can be an effective adjunct to a comprehensive counter-fatigue program when used selectively and with care. Guidance is contained in AFH 11-203 Vol 1 & 2 and AFMAN 48-149. AFRC/SG3P approves dispensing counter-fatigue medication by an RMU for the purposes of ground testing medications under carefully controlled circumstances. There are circumstances during which pharmacologic adjuncts will be used for routine home station flight operations within AFRC. Pharmacologic adjuncts will only be used for operational missions or deployments in support of AMC, ACC, AFSOC, and AFGSC.

ii. The Flight Surgeon will use the Fatigue Avoidance Scheduling Tool (FAST), Fly Awake, or Crew Alert, and other resources. These are important adjuncts to the flight surgeon tasked with joint authority for approval of medication use on selected high-risk missions.

iii. Ground testing is essential to ensure operational use. Ground testing must be done while Aircrew are in status and will be formally DNIF for appropriate time frames per counter-fatigue medication policies. The results must be clearly identified on the DD Form 2766 (section 3 under medications) and the SF Form 600 placed in the Reservist's medical record. ASIMS must also be appropriately updated.

iv. Approval for Medication Use.

a. Approval for the use of Go Pills (Dextroamphetamine/Modafinil) and approval for No-Go Pills (Temazepam/Zaleplon/Zolpidem) is based upon ACC, AMC, AFSOC, and AFGSC approved mission sets.

b. If AF and MAJCOM policy authorize the use of "Go Pills", then the local Wing/CC or equivalent can make an Operational Risk Management decision to authorize their use. The local authority should consult with the unit SGP to ensure other risk mitigation strategies have been considered and implemented.

v. **Medication Handling.** Each RMU must have a written plan that addresses the security, storage, and distribution of controlled substances IAW AFMAN 41-209, Medical Logistics Support. Ensure compliance with all laws, policies, and regulations regarding procurement and handling of these medications as they are Schedule II or IV controlled substances. Under no circumstances should Go and No-Go medications be obtained through prescription written under an AFRC physician's own DEA number.

a. Medications may only be dispensed by a Reserve Flight Surgeon who is on active status. All appropriate documentation must be completed concomitantly with dispensing

.

b. Bases with collocated ADMTF. Coordinate with the local SGP and SGH to develop a method whereby medications for ground testing and pre-deployment or pre-mission issuance can be dispensed.

c. For non-collocated bases:

1. If appropriate storage facilities are available, obtain medications for the purpose of ground testing and issuance IAW AFMAN 41-209. This medication should be obtained through logistics supply form the supporting MTF.

2. If appropriate storage safes are unavailable, it may be necessary to write a prescription for each flyer and have it filled at the nearest supporting MTF.

d. Unused Medication. All unused pills must be returned and that return, and their destruction documented IAW with all applicable policies and procedures.

e. Non-deployed Environment. Use medications for only approved mission sets. Routine home station use is not approved.

vi. **AFRC/SG3P Oversight.** Through the appropriate chain of command, HQ AFRC/SG3P will restrict the credentials of Flight Surgeons who merely "prescribe pills" and fail to implement a comprehensive counter-fatigue management program. Administrative action against these officers and/or their supervisor may be appropriate. It is the Command's position that counter-fatigue management by pharmacologic means alone is a threat to flight safety. SG3P acknowledges that a functional counter-fatigue program to include pharmacologic medications will be difficult to implement by collocated units and extremely difficult to implement by non-collocated units. AFRC/SG3P will be glad to assist any unit with an operational mission need to establish a functional program.

B. Ciprofloxacin. All Reserve aircrew will be ground tested for operational use of Ciprofloxacin. This is to allow for treatment and prophylaxis of Anthrax exposure while deployed. Aircrew may take Ciprofloxacin in standard doses (500 mg every 12 hours by mouth) when directed by theater Commanders or treating physicians and remain on flying status after completion of symptoms free ground test.

i. Ciprofloxacin has been associated with dizziness, agitation, tremors, and other neurological symptoms. Thus, ground testing prior to use is essential. This ground testing must be done while DNIF for 30 hours (18 hours after last dose). Ground testing must be done while Reservist aircrew are in status and will be formally DNIF for appropriate time frames per counter-fatigue medication policies. The results must be clearly identified on the DD Form 2766 (section 3 under medications) and the SF Form 600 placed in the Reservist's medical record. ASIMS should also be appropriately updated.

ii. Ciprofloxacin for ground testing will be purchased through the medical unit's host medical logistics account using wing operations and maintenance funds. WRM stocks of Ciprofloxacin may be used on a reimbursement basis if necessary.

iii. If the Reserve aircrew can give a reliable history of Ciprofloxacin use in the past, with no side effects, this meets the requirement for ground testing. In this case document prior use of Ciprofloxacin as outlined above. If there is no reliable history of previous Ciprofloxacin use, ground testing will be accomplished with 500 mg every 12 hours by mouth for two doses.

C. Medication Stocks. RMUs are not authorized to stock medication except as required to support deployment processing, aviator ground testing, or the administration of immunizations.

D. METLS. Local SGP will submit plan via AFRC/SG3P org box afrc.sgp@us.af.mil for the annual execution and monitoring for local prioritized METALS. See AFMAN 48-149 for list of mission requirements. Some requirements may vary depending on local base mission.

E. RMU/GMU. The medical staff will only perform examinations within the scope of the medical mission, and for those personnel empaneled to that clinic, per AFMAN 41-210. Typically, these exams and services are limited to annual flying exams, initial flying or SOD physical exams, Non-Duty Disability Evaluation System (NDDES), occupational medical exams, Preventive Health Assessments (PHA), incentive flight physicals, and other specific exams needed for AFSC-specific cross-training (e.g., Firefighter) for PS.

i. Per AFRC/A3 memo, *Non-Prior Service Initial Flying Class III Physicals*, and AFRC/SG memo, *Delegation of Aeromedical Certification Authority for Initial Flying Class III (IFCIII) Examinations Without Waiver*, RMU staff will not perform IFC III exams for non-prior service (NPS) Enlisted applicants. NPS

Commission applicants that require an IFC3 exam may be accomplished by the RMU, if the appropriate waivers for such applicants are also processed.

F. The Flight and Operational Medicine Working Group (FOMWG) must and will:

i. Review Aeromedical Information Management Waiver Tracking System (AIMWTS) workflow data including new aircrew/SOD waivers, waiver renewals, and interim follow-up studies, in coordination with the AF 1041 log review. Renewal cases should be submitted to the appropriate waiver authority at least 60 days before expiration. However, if ACS review or evaluation is required, waiver should be submitted 120 days before expiration. If a flying waiver will expire during deployment, request an extension or renewal at least 60 days before the projected deployment date.

ii. Flying Waiver extensions should include the reason(s) why extension is necessary as well as at least a brief discussion of the medical condition(s) requiring waiver, commenting on status, stability, etc. These requests should be emailed to AFRC SGO org box AFRC.SGO.PhysicalStandards@us.af.mil.

iii. If a flying waiver expires, issue a new DD 2992 and DNIF the member until a new flying waiver is approved, or the previous waiver is retroactively extended by the MAJCOM/SG.

G. Mission Qualification Training – RMUs flight surgeons will utilize table 3.1 and must submit all requests for upgrade to 48A/G/R 3-level to the AFRC/SG3P via the org box at afrc.sgp@us.af.mil. MQT Form can be located on the AFRC/SG3P KX FOMC Folder.

Chapter 36
AFI 48-170, *Periodic Health Assessment*

1. References / Further Reading.

A. DODI and DHA PI, 6200.06, *Periodic Health Assessment Program*

B. DoDI 6025.19, *Individual Medical Readiness (IMR)*

C. AFI 10-250, *Individual Medical Readiness*

D. DAFMAN 48-123, *Medical Examinations and Standards* and the Medical Standards Directory (MSD)

E. AFI 48-133, *Duty Limiting Conditions*

F. AFRC/SG3P KX PHA Folder and RHRP Folder

G. BOMC KX

2. Self-Assessment Communicators.

A. 48-170 - *Preventive Health Assessment* (Ground RMUs with AOM UTC mission)

3. Introduction. This instruction (48-170) augments Air Force Instruction (AFI) 10-250, Individual Medical Readiness; AFI 48-104, Tobacco Use in the Air Force; and DAFMAN 48-123, Medical Examinations and Standards. It establishes procedures, requirements, recording of medical standards for Air Force (AF) periodic health assessments (PHAs), and applies to all active duty (AD), Air National Guard (ANG), and AF Reserve (AFR) Airman.

Note: *ANG and AFR are collectively referred to as Reserve Component (RC).*

4. Guidance.

A. Periodic Health Assessment (PHA). All Airmen are required to receive a Periodic Health Assessment (PHA); an annual assessment providing Airmen with mobility related services to maximize their wellbeing and to ensure their mobility readiness. Since members are not deployable without a current PHA, it is a vital part of their Individual Medical Readiness (IMR).

i. The DD Form 3024, Annual Periodic Health Assessment is a web-based self-assessment that is completed via the ASIMS application. Throughout this guide, it will be referred to as the Self-Assessment.

ii. PHAs for Airmen requiring a DD Form 2992 (i.e., Flying and Special Operational Duty [SOD] Personnel) require an annual face-to-face Flight or SOD

exam to ensure compliance with special medical standards outlined in DAFMAN 48-123, *Medical Examinations and Standards*, Chapter 5. In addition, Personnel Reliability Assurance Program (PRAP) PHAs require an annual face-to-face encounter (similar to Fly/SOD members) with a trained Health Care Provider (HCP).

iii. **Newly accessed.** Airmen will accomplish their first PHA during the first 180 days of arriving at their first permanent duty assignment. Newly accessed Airman is defined as members returning from their initial active duty for training period (IADT), i.e., Basic Military Training and Tech School.

iv. **Wing/CC exams.** IAW DAFMAN 48-123, all exams, including PHAs, conducted on a Wing Commander are submitted to AFRC/SGP. RMU will send the completed DD Form 3024, SF 600 PHA entry in the service treatment records, the DD Form 2992 (if applicable) and any supporting clinical records from the civilian provider used to perform the periodic health assessment review to the AFRC/SGP organizational email box (afrc.sgp@us.af.mil).

v. **Out of cycle exams.** PHAs will routinely be accomplished for AFR members in the 10 – 15 months since last PHA window, this is a tier -1 requirements in AFI 48-170 and requires appropriate waiver for any deviation. Out of cycle exam should not be accomplished to facilitate any mass PHA event, of any sort. AFI 48-170 does provide exemptions to this rule that do not require a waiver.

vi. **Standard operating procedures and protocols.** The RMU Chief of Professional Services (SGH) and Chief of Aerospace Medicine (SGP) will develop local protocols or standard operating procedures (SOP) that establish the criteria by which a face-to-face appointment is required. These protocols and/or SOP will be reviewed on an annual basis and the most current version attached to the Self-Assessment Communicator (SAC) in MICT for the governing Air Force Instruction, 48-170.

vii. **Clinical Preventive Service (CPS).** While provision of preventive services, e.g., cholesterol, PAP, fasting blood sugar, etc., by the RMUs is not permitted; PHA providers should counsel and advise members on CPS recommendations per the United States Preventive Services Task Force Guide to Clinical Preventive Services (www.uspreventiveservicestaskforce.org). This counseling should be documented in the PHA and RMUs should request member submit results of these CPS if accomplished, document review of such by a provider, and file in the service treatment record.

viii. **Reserve Health Readiness Program (RHRP).** RHRP is a Department of Defense, Defense Health Agency program that helps to supplement the Reserve Components' readiness mission and satisfy key deployment requirements by providing medical and dental services to all Reserve Component forces through IMR services. RMUs may request available RHRP services, which include PHA

services, via onsite group events or individual in-clinic appointments via the LHI Portal, information on the LHI portal is found in the AFRC/SG3P RHRP Folder.

B. PHA Components. The PHA consists of four components: service member self-assessment, medical record review, person-to-person MHA, and review and disposition by a trained/privileged military healthcare provider.

i. Service Member Self-Assessment (SA). Members are automatically notified that they are due for a PHA via a system-generated email from Aeromedical Services Information Management System (ASIMS). The member then completes the online Self-Assessment.

Note: *The term Unit Health Monitor (UHM) was removed from AFIs 10-250 and 48-170. However, each Unit/CC is still responsible for appointing personnel from the Commander Support Staff to receive ASIMS access and as note din in 10-250, "…help monitor Unit individual medical readiness, and serve as a unit liaison with the Base Operational Medicine Clinic." Which includes scheduling of PHA appointments.*

ii. Medical Record Review (MRR). A review of the member's Service Treatment Record (STR), both the composite (hard copy) and Electronic Health Record (EHR) will be conducted to identify potential medical readiness concerns, Occupational Specific Examinations, Deployment-Related Health Assessments (DRHA) (if applicable), other IMR requirements and all recommended lab work, immunizations, tests, specialty services, etc. Additionally, requests for civilian provider records needed to make a medical readiness determination or any necessary should be made in this stage.

iii. Person-to-Person Mental Health Assessment (MHA). Non-Fly personnel will utilize the Reserve Health Readiness Program (RHRP) vendor, Logistics Health Incorporated (LHI), at LHI.care to schedule the annual Mental Health Assessment (MHA) portion. Member will be contacted directly by LHI via phone at the prescribed/scheduled time to accomplish the MHA. Flying/SOD personnel will complete the mental health portion during their face-to-face flight or SOD/exam. Training and an overview of the RHRP MHA/PHA process can be found at the AFRC/SG3P KX PHA Folder.

iv. Health Care Provider Review and Disposition. A trained/privileged military health care provider will review/validate the Self-Assessment and make any necessary recommendations and referrals necessary to make the necessary medical readiness determination. This includes any necessary CPS from civilian providers. The Cardiac Risk Assessment (CRA) is not required as a standard/recurring requirement. However, providers should still consider cardiac risk factors in the PHA, and if warranted based on other risk factors, request either a civilian provider performed CRA, or a current cholesterol screening from the civilian provider to run the CRA themselves. This should be reviewed by a

provider and recorded in the STR. The CRA Tool is located on the AFRC/SG3P KX PHA Folder.

C. PHA Process Participants.

i. Air Force Reserve Member. AFR members are responsible for their PHA/IMR/DRHA requirements and can access the "Fitness & Health" and "Medical Readiness-Deployment Health (My IMR)" links on the Air Force Portal to address any deficiencies. The site can also be accessed directly from any computer with a valid Common Access Card (CAC) and CAC reader.

ii. PHA Team. The PHA is overseen by the Chief of Aerospace Medicine (SGP). The team consist of the PHA Manager, full time Air Reserve Technician (ART)/AGR staff and necessary supplemental Traditional Reservists (TR) staff. The PHA team is responsible for facilitating and managing all PHAs for personnel assigned to their Wing as well as any Geographically Separated Units (GSU) physically located at the same location as the RMU. The PHA Team performs key tasks which include but are not limited to:

a. Record keeping, tracking, processing, provider/technician level peer review of all PHAs, standardized PHA process for all Wing/GSU assigned personnel to include waiver management and DD Form 2992 processing.

b. Reviews and updates STR, which includes the composite/hard copy records in addition to all EHR systems to include, Armed Forces Health longitudinal Technology (AHLTA), Joint Legacy Viewer (JLV), and Health Artifact and Image Management Solution (HAIMS), and ASIMS.

c. Orders and reviews appropriate laboratory testing, conducts person-to-person exams (if/when required or at the request of the service member), reviews member's AF Form 469 and/or 422, and makes occupational and Worldwide Duty Qualification (WWQ) determinations.

iii. Non-Medical PHA Partners. Unit Commanders, First Sergeants, and Unit CSS are vital to the success of the PHA program. It is recommended, for continuity purposes, that either the primary or the alternate Unit CSS POC be a full-time member of the unit ART/AGR staff. IAW AFI 10-250 1.10.3., the unit commanders must provide an appointment letter to the ASIMS Administrator, before their Unit CSS POC will be added to the ASIMS Unit POC Email List, allowing access to the Unit IMR Reports. A sample appointment letter is located in the AFRC/SG3P KX PHA Folder. Real-time Unit IMR currency reports are also available to Unit CCs, First Sergeants, and Unit CSS POCs through the ASIMS Unit POC Module for use in managing unit compliance. Unit CSS POC

responsibilities are outlined IAW AFI 48-170, paragraph 2.8 Commander Staff (CSS).

Note: *As directed by AFI 48-122, Unit Deployment Managers (UDM) are the unit level POCs for managing the success of the DRHA program and monitoring timely completion of the DRHA questionnaires.*

D. Department of Defense PHA Part Breakdown.

i. Airman Self-Assessment (Part A). AFR members complete their annual PHA utilizing DD Form 3024. If the PHA is more than 12 months (365 days) old, a new PHA is needed. In ASIMS, a color system is used to describe the PHA status: green (current), yellow (due), and red (overdue). When a PHA becomes due, there is a three-month (90 day) yellow period. When the three-month yellow period expires, the PHA becomes overdue, or red. Member are counted as Green for IMR reporting purposes through the entirety of the Green and Yellow period (15 months).

a. ASIMS will send an automated system generated email to notify members 60 days in advance of their PHA (10 months since last PHA date) due date and once a month after that until complete. If a member needs to complete their Self-Assessment, the My IMR web application page has a "Start PHAQ" button that the member can use to initiate their Self-Assessment. The Unit CSS POCs can monitor compliance status via the ASIMS Unit POC Module in coordination with the PHA Team. The ASIMS Unit POC Module was specifically developed to allow Unit CCs and Unit CSS POCs the opportunity to monitor and track their members' compliance with not only PHA, but also all IMR and DRHA requirements.

b. ASIMS will send an automated system generated email to notify members 60 days in advance of their PHA (10 months since last PHA date) due date and once a month after that until complete. If a member needs to complete their Self-Assessment, the My IMR web application page has a "Start PHAQ" button that the member can use to initiate their Self-Assessment. The Unit CSS POCs can monitor compliance status via the ASIMS Unit POC Module in coordination with the PHA Team. The ASIMS Unit POC Module was specifically developed to allow Unit CCs and Unit CSS POCs the opportunity to monitor and track their members' compliance with not only PHA, but also all IMR and DRHA requirements.

c. Members who do not complete the Self-Assessment within the specified time-period should receive a follow up notification from their Unit CC, First Sergeant, or Unit CSS POC. Upon completion by the member, the Self-Assessment is valid for 120 days. If the

RMU has not started reviewing any portion of the Self-Assessment within 120 days, it will be automatically archived, and the member will be prompted to re-accomplish the assessment.

d. DRHA 1/2/3 can no longer be used in place of the Tri-Service PHA Self-Assessment (DD Form 3024).

e. DRHA 4/5. The DD Form 3024 V2 (released 9 Aug 21), will be accepted for DRHA4/DRHA5 in accordance with DAFI 48-122, *Deployment Health.* RMU staff looking for DRHA 4/5s for review purposes should search service member's PHA that falls within the appropriate period.

f. The Self-Assessment must be completed online. If necessary (e.g., no electronic resources are available), a paper DD Form 3024 can be searched and printed online and will have the word, "SAMPLE" stamped across it. If a hard copy is completed for any reason, the DD Form 3024 will be transcribed into ASIMS within the PHAQ Menu and hard copy will be filed appropriately in the composite STR or digitized to HAIMS and associated with the AHLTA/MHS Genesis encounter, as applicable.

g. Flying and SOD personnel are not required to call LHI following completion of Part A of the Self-Assessment. Flying/SOD personnel will complete both sections of Part C (Mental Health and Health Care Provider) as a face-to-face encounter with the Flight Surgeon.

h. All Other Airman, to include Personal Reliability Assurance Program (PRAP), must complete the Self-Assessment and schedule an MHA appointment as shown at the end of the Self-Assessment with the RHRP vendor, to complete the MHA portion prior to their scheduled completion of the health care provider portion of the PHA.

E. Record Review and Recommendations (Part B). The record review process occurs after the Service Member completes the Self-Assessment. If necessary, the record review can occur simultaneously with the MHA. The HCP portion cannot be accomplished until both the record review and MHA are finalized. The record review process includes:

i. Reviewing responses to the Self-Assessment and comparing them to the medical history in the Service Treatment Record (STR) and Electronic Health Record (EHR).

ii. Ensuring the most current vitals are documented.

iii. Reviewing currency of IMR and/or DRHA requirements and identifying any conditions that may cause Duty, Mobility, or Fitness restrictions.

iv. When identifying significant past medical history during the record review document findings in the following three categories:

a. Chronic:

1. Lasting longer than 6 months (i.e., cough)

2. Persistent in nature (i.e., low back pain)

3. Controlled but not cured (i.e., hypertension, diabetes)

b. Pertinent:

1. Relevant or relating to a condition

2. Required excusal (i.e., quarters, convalescent leave)

3. Profiled conditions or changes

4. Specialty referrals

5. Grounding or suspension from flying duties

6. Requiring ER/Urgent Care visits or hospitalization

c. Critical:

1. Anything that can result in loss of life, limb, or eyesight (i.e., macular degeneration, uncontrolled diabetes)

v. All new patient information identified on the Self-Assessment will need to be documented, to include:

a. Civilian provider care/treatment/evaluations and all requests made to request additional records (to include CPS).

b. Dates and/or results for vitals, lab work, and vaccines received

c. Dental readiness

d. List of current medications and allergies

e. Review status of Profiles/Assignment Limitation Codes (ALC) and Waivers

f. Identify members on temporary duty limiting conditions (DLC) and note duration and diagnosis

g. Document any other pertinent medical information in the additional comments for the PHA provider.

vi. In addition to the completion of the DD Form 3024, Part B, the record reviewer will, in ASIMS, update the DD Form 2766 in the Edit Full DD 2766 tab, update the DLC Review date in the 469/422 tab, and create a chart note within AHLTA/MHS Genesis or paper STR ASIMS overprint, as applicable.

vii. In the example below, the member has a cumulative total of 1095 days on a MR profile. This information is important to note for the provider to determine whether member is currently on an Assignment Limitation Code (ALC) X, Y, or C, or whether the member will need to be or has been referred to the AMRO board for review and/or action.

Asg Limit Code 1:	Asg Avail Code 1:	TB	Current effective record has a cyan background
Asg Limit Code 2:	Asg Avail Code 2:	TE	Open records are not included in the IMR status
Asg Limit Code 3:	Asg Avail Code 3:	37	ICD > 365 days MR: R00.2 (1095 d), Z95.0 (1095 d)

F. Critical Findings. The 25 Sept 2020 issuance of AFI 48-170 removed the critical category and response times from the PHA process. However, the 'Critical" response does still exist in the MHA and DRHA process with a 1 duty day contact from a provider certified in conducting DRHA/MHAs. RMUs that identify critical responses in the PHA record review process related to MHA responses are encouraged to utilize the established process to request an immediate MHA completion by the RHRP via vendor LHI Portal, details can be found on AFRC/SG3P KX RHRP Folder. This may be accomplished for all personnel, both Fly/SOD and non-fly/SOD.

G. Priority Findings. Per AFI 48-170 (25 Sept 2020), priority findings are primarily focused on MHA related responses and requirement for MHA providers to address "priority" responses person-to-person within seven calendar days. The RHRP vendor MHA process is designed to meet this requirement by presenting appointments to member via LHI.care within the required 7 days based on ASIMS flagging of results from member Self-Assessment. As this is reliant on member's scheduling and adhering to appoints in the seven-day window, the PHA Team will need to monitor completion of these encounters between member and RHRP vendor and notify Unit CSS if not completed in 7 days. For Fly/SOD personnel who do not present for service to RHRP vendor automatically via ASIMS accomplishment of self-assessment, the RMU will need to either; 1) utilize full time provider trained on MHA process (if available) to contact member or 2) make request for service by the RHRP via vendor LHI Portal, details can be found on AFRC/SG3P KX RHRP Folder.

H. Routine Findings. After reviewing Routine findings under the Record Reviewer List in ASIMS, the PHA Team will determine how each finding will be addressed based on local standard operating procedures or protocol established by the SGP and SGH. It is recommended, as time permits, that the PHA Team conduct a person-to-person encounter with the member to further discuss Routine finding(s), and request additional records as necessary.

Note: *Current policy is not directive in nature regarding person-to-person contact in the PHA process. RMU PHA Team with SGP and SGH drafted standard operating procedures and/or protocols should be proactive in establishing procedures for contacting members, to not only address findings from the self-assessment, but also requesting of records from civilian providers. RMUs are not health care providing facilities like ADMTF and are therefore reliant on member inputs in self-assessment phase, the record review and civilian records to ascertain the medical readiness of an Airman. The record review and procurement of necessary records from member's civilian provider is crucial to providing all the information necessary for the next portion of the PHA to be efficiently accomplished. ALL attempts to contact the member regarding Critical/Priority/Routine findings and requests for civilian records will be documented in the "Add Note" section in the patient summary view until the member is contacted.*

I. Health Care Provider (HCP) Review (Part C). The Health Care Provider (HCP) review is the final part of the PHA process. HCPs will be trained in the PHA/MHA process. Part C is a two-part process:

Step 1: Mental Health Assessment (MHA). All privileged/trained military providers are authorized to conduct MHA/DRHA reviews and dispositions. The training can be found on the JKO website, search for course number US332. Certificates for the AFI 48-122 prescribed training must be submitted to the MTF Credentials Manager for uploading/maintenance in the Centralized Credentials Quality Assurance System. Training for IDMTs must also be documented in the Air Force Training Record.

Step 2: Periodic Health Assessment (PHA). HCP reviews the Self-Assessment, record reviewer inputs, validates current medications, and health history since last PHA. All discussions with the service member will be documented in both Part C, and in AHLTA/MHS Genesis or hard copy in the composite STR.

Note: *If using AHLTA, copy and paste ASIMS information to the "Add Note" section of the AHLTA 600 in disposition section.*

i. Person-to-person encounters for non-fly/non-SOD/non-PRAP/PRP/PSP are conducted as indicated by the service member's Self-Assessment, the service member requests to speak to a provider, or based on the results of the record review. SGP and SGH will establish local SOPSs and protocols/criteria in writing to determine which service members will require face-to-face examinations.

ii. Flying/SOD and PRAP personnel require face-to-face annual examinations.

iii. The DoD PHA is considered current and complete when the HCP accomplishes the following:

a. Entirety of the DD Form 3024 with both the MHA and HCP provider portions signed and completed in ASIMS.

b. Either 1) electronic entry made in the EHR (MHS Genesis or AHLTA) documenting the PHA or 2) hard copy SF 600 completed and signed, scanned, and uploaded to HAIMS with the DD form 3024 and all other supporting records.

Note: *ASIMS is the AF readiness platform and IS NOT a component of the Electronic Health Record (EHR), completion of the PHA in ASIMS only DOES NOT meet the requirement to ensure the PHA is documented in the EHR.*

c. Member informed of all required follow up items if warranted.

d. IMR, AF Form 469/422, DD Form 2992, and PHA completion date have been updated/validated

iv. Interim History. The HCP provider portion of the PHA should be completed within 120 days of member completion of self-assessment. If this timeline cannot be met, the ASIMS self-assessment does not need to re-accomplished; instead, the SF 507, *Health History Questions/Interval History,* can be utilized, available on the AFRC/SG3P KX PHA Folder.

v. Gambling Disorder Screening. DHA-PI 6200.07, *Inclusion of Gambling Disorders on the Periodic Health Assessment,* directs inclusion of gambling disorder screening into the PHA process. Guidance and references are located on the AFRC/SG3P KX PHA Folder.

vi. Burn Pit Registry. The FY 2020 NDAA, sections 704 and 705 directed Services to evaluate and document service member exposure(s) to open burn pits and/or toxic airborne chemicals/contaminants. This requirement has been captured in both the PHA (DD Form 3024) as well as DRHAs (DD Forms 2796, and 2900). All necessary screenings questions and information for the member on how to register, if not already enrolled, have been added to ASIMS questionnaire/self-assessment process. Members indicating, they are enrolled in the burn pit registry and presenting documentation of such should prompt a provider visit to ensure these exposures are documented in the Electronic Health Record (EHR), if not already recorded. REMINDER, ASIMS is not part of the EHR and an entry into the EHR must occur.

vii. DD Form 3024 V2 (PHA). On 9 Aug 2021, the DD Form 3024 underwent significant updates capturing several interim revisions. This update also

incorporated the necessary logic and triggers for deeper review/assessment for items such as the depression and PTSD.

J. Documenting the Tri-Service PHA. There are three avenues by which the PHA can be documented. The result of each is recording of the PHA in the electronic health record (EHR). While action to accomplish the four elements of the PHA and record completion as part of overall IMR roll up reporting are accomplished in the Air Force readiness platform (ASIMS), entry into the EHR is required as well.

i. Hard Copy with upload to HAIMS. RMUs may accomplish a hard copy SF 600 with a full SOAP note to document the PHA, completion of which will be uploaded to HAIMS with the ASIMS generated DD Form 3024, and any other supporting civilian records related to the PHA medical readiness assessment within 3-5 business days following encounter. Uploading the entirety of the PHA to HAIMS meets the requirement for entrance of the PHA into the EHR. All composite hard copy service treatment records should either have been submitted to the STR cell for digitization or closed if still maintained on site by the RMU. In either situation, no further records should be added to the composite hard copy records and all additions to the STR will be via upload to HAIMS as late loose flowing documents (artifacts) with metatags.

ii. Electronic encounter in AHLTA. Follow existing AHTLA business rules for recording of PHA. This option is only available at sites that have not or are not imminently converting to MHS-Genesis.

iii. Electronic encounter in MHS-Genesis.

Note: *Useful technical instruction on the use of AHLTA or MHS-Genesis can be located on the AFRC/SG3A Kx.*

iv. RMU transition to electronic encounters. RMUs that wish to convert to accomplishing PHAs via electronic encounters should complete the "EHR Transition Checklist" located on the AFRC/SG3P KX PHA Folder, and submit to both AFRC/SG3P (afrc.sgp@us.af.mil) and AFRC/SG3A (HQAFRC.SG3A.WORKFLOW@us.af.mil), prior to conversion.

K. Remote PHA. There may be circumstances that should be outlined in local business rules and clinical decisions, which may allow some Airmen to complete their entire PHA remotely (e.g., telephone, video link). Under normal operations, clinically indicated visits are meant to be in-person. Under exceptional circumstances (e.g., COVID-19 response/operations), virtual visit may be authorized via established deviation from normal operations procedures. Absent authorized deviations, these visits are intended to be in-person.

L. No Show/Incomplete Reports. If the member does not show up for their PHA, the appropriate PHA team member must enter the date in the "No-Show" field in ASIMS. Recording the "No-Show" is crucial. If it is not recorded, missed appointments cannot be tracked – a key reporting requirement for RMU Commanders. The ASIMS Unit POC Module contains a "PHA No-Show Report" which is accessible to Unit CCs, First Sergeants, and CSS POCs at any time.

i. Units track their Airmen who have failed to meet PHA suspense or who have excessive short-notice cancellations or missed appointments for scheduled services. What constitutes "excessive" short-notice cancellations or missed appointments will be determined at the installation or RMU level.

ii. Airmen and their leadership (Unit CCs, First Sergeants, & Unit CSS POC) are responsible to ensure members complete all portions of the PHA. Airmen and their leadership can view PHA requirements (via My IMR and the ASIMS Unit POC Module). Airmen with incomplete PHA requirements are notified. As a "Commanders Program," Units can/should hold members accountable for "No-Shows," and incomplete PHA, IMR, and DRHA requirements.

M. Sister Service PHA – Situational Awareness Only. RMU is WILL NOT complete Sister Service PHAs without prior authorization from AFRC/SG3P, completion of a MOU/MOA, as necessary and appropriate manning to support the additional workload. ASIMS Sister Service Guidance is located in the AFRC/SG3P KX PHA Folder.

N. VA Disability Rating in ASIMS. AFR members with a disability rating pose a potential readiness concern. Members with unidentified conditions may inappropriately be leveraged in military duties that could pose a risk to themselves and mission safety. A VA rating alone does not indicate a member does or does not meet retention standards IAW DAFMAN 48-123, Medical Examinations and Standards; however, this flag is intended to identify to the Reserve Medical Unit a potential condition that must be addressed.

i. ASIMS users at the RMU who see a VA% flag on the members IMR will take the following actions to reconcile and ensure medical conditions are accounted for:

a. Review entire STR, HAIMS, AHLTA and JLV, this should be a one-time review, once reviewed there is no need to complete continuous deep dives into SM medical records. Proper review the first time is key and a note to other PHA Team members should be clearly annotated in the SM medical records.

b. If new or currently un-identified conditions are noted, they should be appropriately documented and dispositioned IAW DAFMAN

48-123, the Medical Standards Directory (MSD), and AFI 48-133. If the member is identified as having failed to report significant medical conditions IAW AFI 36-2910 and DAFMAN 48-123, the RMU should notify the commander while still issuing the proper DLC/profiling, disposition, and case management steps.

c. If the RMU cannot reconcile the disability percentage via review of STR and accessible electronic records, they will request that the member provide a copy of the most current VA disability award letter and the VA disability C&P (compensation and pension) exam itself that matches the disability rating in ASIMS.

d. Aeromedical Services Information Management System (ASIMS). Best used for by name listing of IMR deficiencies. Web based program used by the Air Force population to manage and track individual medical readiness requirements. While ASIMS data is computed in real time, it does not eliminate members with certain DAV codes. Therefore, ASIMS overall IMR metric should not be utilized for reporting purposes. ASIMS is a "work" tool that feeds AFCHIPS. Members of the AFR populate in ASIMS once assigned to an AFR PASCODE and remain in ASIMS until removed from the PASCODE but are eliminated from the calculation at the AFCHIPs roll-up level, if properly DAV coded.

Chapter 37
AFI 90-5001, *Integrated Resilience*

1. References / Further Reading.

A. DAFI 40-301, *Family Advocacy*

B. AFI 44-119, *Medical Quality Operations*

C. AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*

D. AFI 44-153, *Disaster Mental Health Response & Combat and Operation Stress Control*

E. AFI 44-172*, Mental Health*

F. DODI 6490.16, *Defense Suicide Prevention Program*

G. AFPD 90-50, *Integrated Resilience*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This AFI establishes requirements to conduct education and training to prevent acts of harm to self and raise awareness to prevent suicide and suicidal behavior in Air Force (AF) communities.

4. Guidance.

A. Air Force Reserve Suicide Prevention. Procedures for Managing Suicidal and/or Homicidal Reserve Personnel.

i. HQ USAF/SG dictates that every individual who communicates, directly or indirectly in any manner (e.g., verbally, in writing, through social media, behaviorally, by a change in demeanor, etc.), that he or she has currently or recently had thoughts, intentions, or plans to harm his or her self, other persons, or property will have safety precautions implemented and receive an ASAP, face-to-face clinical evaluation.

a. The evaluation must be conducted by a clinically privileged provider IAW current legal guidance and other standards of care.

b. RMU's do not have privileged military providers authorized to perform safety or diagnostic assessments. Potential suicide and/or homicide are situations that should be handled via local EMS resources.

c. RMUs should consult their Director of Psychological Health (DPH) for guidance.

ii. RMUs and other units will establish and maintain mechanisms for the timely referral and evaluation of any person considered to be potentially suicidal, homicidal, or destructive and advise the member's Commander IAW current Air Force policy.

a. Each unit will have written plans and checklists to immediately manage potentially dangerous situations. Collocated and associate units will refer individuals directly to the active duty MTF emergency services (if available) or to civilian EMS. Non-collocated units will utilize civilian EMS and civilian medical facilities.

b. SGH ensures training for all clinic members to assess and be aware of suicide risk while in clinic on the UTA weekends.

Note: *Remember to keep in mind that DPH and RMU clinicians may NOT treat during UTA weekends, however they must recognize and refer members at risk for suicide. This includes warm hand-off if the risk is imminent.*

c. Ensure that commanders are briefed on status of member. Remind commanders of the limitation of the UTA physician. For those associated with Substance Abuse, the SQ/CC may place a member on orders for the evaluation only, but not for treatment IAW AFI 44-121.

d. Keep a log and discuss in AMRO to ensure that the member does not fall through the cracks or off the radar.

e. Ensure that the Wing/CC and SQ/CCs are aware of https://www.resilience.af.mil/ and the prevention, intervention, and post-prevention tools.

f. Ensure DODSER completion for suicides and suicide attempts.

iii. Reservists that receive emergent referrals for suicidal, homicidal, destructive, or psychotic communications or actions will immediately be made AAC 31 until a Military Mental Health Evaluation (MMHE) which will help establish the next course of action.

B. Reporting Suicide Attempts and Suicide Deaths. Suicide attempts and suicide deaths will be reported and reviewed after the event IAW current DoD, AF, and HQ AFRC guidance [Suicide Prevention Program and/or DoD Suicide Event Report (DoDSER) found online at: https://health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/Department-of-Defense-Suicide-Event-Report or by searching for "DoDSER"].

C. Suicide Attempts. All suicide attempts require that the member's world-wide duty qualification be addressed through one of the following: IRILO, NDDES or MEB (based on LOD).

i. Airmen who attempt suicide are at high risk for several adverse outcomes. Their fitness for military duty must be carefully evaluated to ensure a successful mission and the safety of coworkers, family members, and the individual. This requires a comprehensive mental health evaluation by an Active-Duty Mental Health Provider and must address all items outlined in the narrative summary.

ii. MEB will be accomplished for suicide attempts found in the Line of Duty if the IRILO found member disqualified. Airman whom attempt suicide when in military status will be carefully evaluated for both ongoing care and fitness/suitability for continued military duty. Airmen with a personality disorder, should have their case referred to their Commander because personality disorder diagnoses may render an individual unsuitable rather than unfit for service and subject to administrative discharge (ref: MSD Section Q. Note 1.)

iii. A Non-Duty Disability Evaluation System (NDDES) case will be accomplished for suicide attempts found NILOD if disqualified in the IRILO phase or if the RMU AMRO chooses to bypass the IRILO phase. Airmen who attempt suicide while not in a military status will require assessment of their continued qualification for military duty. However, they will not be processed through the MEB at the AD MTF unless the underlying diagnosis has been previously deemed service connected via a LODD. If there is no service connection, the RMU will process a medical evaluation per this policy.

D. Suicide Deaths. All events will be reviewed and reported in DoDSER by a privileged military medical provider. A DoDSER is required for all Reserve suicide deaths, regardless of status. Direct all questions to HQ AFRC/SG3P, Command Mental Health Officer or encrypted via AFRC.SGO.PhysicalStandards@us.af.mil. The case may be chosen for review in the future at a MAJCOM level Suicide Analysis Board (SAB).

E. Documenting Suicide Prevention Training. All suicide prevention training will be recorded in the Advanced Distributed Learning Service (ADLS). Commanders are responsible for ensuring that unit training managers, or their designee, manually document the training in ADLS to ensure individuals receive full credit for the "in-person" training.

F. Reporting Suicide Prevention Training. HQ AFRC/SG3P is the Subject Matter Expert (SME) for the clinical and response elements of AFRC Suicide Prevention Program (AFRSPP) and the HQ AFRC Community Action Team (CAT) chair is the OPRF for collecting training reports. Semi-annually, the wing CAT chair will forward training reports to the HQ AFRC CAT chair. The HQ AFRC CAT chair will then report the wing's training status as requested or required.

Chapter 38
AFI 90-6001, *Sexual Assault Prevention and Response (SAPR) Program*

1. References / Further Reading.

A. AFI 36-2910, *Line of Duty (Misconduct) Determination*

B. DAFI 40-301, *Family Advocacy*

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. This AFI assigns responsibility for the prevention of and response to sexual assault and establishes command relationships, authorities, and responsibilities in support of the policy.

4. Guidance.

A. Reserve SAPR Liaison (RSL). Every Reserve Wing must appoint an RSL and an alternate. The primary duties entail assisting the SARC with Reserve unique LOD issues and benefits associated with the LOD such as access to care, MEDOCN/INCAP and MEB/IDES processing. This role will be appointed from personnel within the RMU with the AOME mission by the Wing/CC. Appointed POCs should be part of the full-time staff and familiar the provision of both AFI 90-6001 and 36-2910, especially with regards to Restricted/Un-restricted sexual assault reporting and how LODs, MEDCON and INCAP requests should be processed for those member that request restricted reporting. The RSL is not to perform SARC nor Victim Advocate related duties. The RSL is also not responsible for any other program oversight related to the SAPR program as noted in AFI 44-102, to include tracking and monitoring of required training, these duties and this role are separate from the RSL and is appointed by the RMU/CC. The RSL only acts as a liaison for the SARC for LOD related issues for sexual assault victims.

Chapter 39
AFRC/SGO Specific Guidance

1. References / Further Reading.

A. See AFRC/SGO folder on the SG3P KX for other guidance.

B. On call number, M-F and UTA weekends (Primary) 0800-1600 EST, Technician – 478-222-9072, Provider – 478-222-9172

2. Self-Assessment Communicators. None are applicable currently.

3. Introduction. Air Force Reserve Command (AFRC) has provided important elements regarding medical qualifications for participation, compliance with medical requirements/standards, LOD, IRILO, NDDES, MEB, etc. All RMUs will familiarize themselves with this content.

4. Narrative Summary.

A. Though clinical documentation is required for medical cases, the narrative summary should be able to stand alone to tell the story of a patient's overall health status.

B. The RMU technicians may only complete the Demographics, Medication, LOD, and Profile sections of the NARSUM.

C. Narrative Summary (NARSUM). Instructions to the military provider preparing the summary:

i. **Purpose of the Narrative Summary.** The NARSUM should stand on its own in supporting the action you are recommending. In other words, the reviewer should not have to turn to any accompanying documentation to decide.

ii. **Sufficient Information.** Include sufficient information in the summary in a concise but detailed format. There is no way the reviewer can know everything you do unless you put it down in the NARSUM. However, including extraneous data that does not directly apply to the case is extra work for you and may confuse the reviewer as to why you included it.

iii. **Required Specialty Consults.** Paraphrase or quote in the summary key information obtained in consults, but remember to include copies of the consults, laboratory values, imaging, and ancillary testing (stress treadmill, PFTs, etc.).

iv. **Medication.** Include all past and present medication pertaining to potentially disqualifying conditions, dosages, and compliance of usage.

v. **Medical Standards Directory (MSD) Inputs.** Be sure to address all disqualifying conditions and potentially disqualifying conditions (those listed in the MSD but meet retention standards) in the summary. Check the KX for the most current MSD.

vi. **Required Conclusions and Recommendations.** You will make conclusions and recommendations for full case processing, RTD no restrictions, or ALC restrictions and base them on the facts stated in the summary. Avoid emotionally charged, non-medical facts or medical presumptions that are not supported by evidence-based data. Tell the waiver authority what you feel is appropriate for the case. Do not be afraid to recommend disqualification or qualification, if you truly feel that is in the best interest of the individual and the Air Force.

vii. **Occupational.** Reference how all the current medical conditions, whether potentially disqualifying or not, affect the member's duties regarding their AFSC, grade, and office to include deployed and in garrison.

viii. **Line of Duty (LOD) Statement.** Ensure that the NARSUM is clear that the condition and any other worldwide duty disqualifying conditions mentioned in the NARSUM are not in the line of duty. Often members allege line of duty at the PEB level. This issue is best dealt with prior to PEB review.

a. Due to continued scrutiny by the IPEB and FPEB regarding service member claims for LODs, detailed explanations are required in Section 9 of the NARSUM to mitigate cases (specifically Non-Duty Disability Evaluation System (NDDES) being returned by the IPEB. The LOD status of all disqualifying conditions need to be addressed in detail in section 9, a simple "Yes," "No" or "N/A" will not suffice. Please address the issue specifically in the NARSUM. Informal AF Form 348 adjudication is not necessary. The reviewer may agree or disagree since they have other case histories, as well as expert consultants, to help them with the final decision.

1. Example: If a LOD was never accomplished because member was not in a valid duty status please state why; "No evidence has been provided to indicate this condition was either in incurred or aggravated while in a Reserve military status."

b. Conditions originating from any branch of service requires a detailed analysis similar to what the medical officer is required to complete during an actual LOD work up addressing: EPTS, Service Aggravation (yes or no), was the member "Fit For Duty" when they left prior branch of service or erroneously separated from prior branch of service with an unaddressed disqualifying condition, was there intervening worsening of the condition overtime while not in military status, etc.

ix. Final Considerations. Make sure the narrative summary addresses the impact of the medical condition on the ability of the individual to do their job based on AFSC (refer to the Enlisted Classification Directory or Officer Classification Directory for description of job duties) both in-garrison and deployed. To find these documents go to https://mypers.af.mil and click on Classification.

5. Clinical Documentation.

A. Review all available hard copy and electronic medical records (composite STR, AHLTA, HAIMS, JLV, MHS-Genesis, etc.) This task should be accomplished by both technicians and providers and should also be accomplished prior to submission of the completed case. This is to ensure no pertinent updates have occurred that need to be addressed.

B. Does not include discharge instructions, patient summaries, letters from providers

C. Needs to be legible, no blank pages, and right-side up

D. Include pertinent documentation but do not make the reviewer dig through huge volumes of paperwork to find supporting documentation or to answer a question.

i. Initial/Final copy of diagnosis, PT notes, inpatient admission/discharge, and specialty consults, etc.

E. Ensure the records attached to a case are for the correct member.

F. All documentation must be reviewed by a privileged military medical provider

G. JLV Records in support of ECT cases. The RMU will state which JLV entries they are referencing in support of the case in the narrative summary, to include:

i. Date of document

ii. Specialist

iii. A summary of the document

Note: *All LOD cases will need to include clinical documentation in the case that pertain to the diagnosis.*

Note: An example of the above would be, *"Reference ECT entries 12 Jan 2016 for Orthopedics, 22 Jan 2016 MRI, and 4 Feb 2016 Family Medicine, which supports the diagnosis of torn ACL."*

H. HAIMS. All medical documents from civilian sources must be uploaded in to HAIMS and uploaded in to ECT.

6. Guidance.

A. ECT RMU Guidance. The Electronic Case Tracking system is integral to the efficient and timely adjudication of a variety of cases submitted for AFRC/SGO review and action. The following is provided for informational purposes to help the RMU enter the case into the correct queue and avoid delays.

i. RMU ECT Process Implementation. The following information gives the RMU guidance on how case will be accomplished before being submitted to AFRC/SGO for adjudication. Any case that comes to AFRC/SGO will be reviewed first by a technician for completion (i.e., all required documentation is uploaded into ECT). If the case is deemed unworkable, it will be "Returned for Action" (RFA) to the RMU for correction.

ii. If the case is missing any items when it comes to the AFRC Board Technician, but it is still considered "workable," the technician will post a comment in the Case Dialogue Tab of ECT that the RMU was notified via emailed what items need to be uploaded, but the case will still be forwarded to the AFRC Board Medical Officer for review. This will reduce the number of times that a case has to be RFA to the RMU and allow work on the case to continue. RMUs may send updated records at any time to the org box at AFRC.SGO.PhysicalStandards@us.af.mil as new updates/records become available. The SGO technician will be able to upload new documentation to the case to avoid case being moved back and forth.

iii. ECT allows for 5 MB per uploads

iv. Documents should be in **PDF** format

v. Documents should be grouped together by category, i.e., primary care, Ortho, PT, Labs, radiology, etc.

vi. Documents should be uploaded and labeled in chronological order newest to oldest

B. ECT Commander Guidance.

i. RMU responsibility.

a. Grant access to ECT for all commanders

b. Explain the tracking system of ECT to the all newly assigned commanders:

1. LOD case processing

2. All other case tracking, i.e., IRILO, NDDES, DW, RW, etc.

7. Case Types in ECT. Each section is labeled to reflect the different queues within ECT that should be used for case.

A. LOD. These cases are for members with illness, injury, or disease which were potentially incurred or aggravated during AFR military service, i.e., IDT, AT, RPA, MPA, and/or EAD. Prior service injury, illness, or disease will not be considered for LOD processing by AFRC, unless service aggravated in AFR military service.

i. RMU Process for Requesting LOD.

a. Refer to Chapter 9 for specific information

b. If condition requires mobility or duty restrictions notify MSME.

c. Review EHR and STR for relevant documentation.

d. Have member complete DD Form 2870 or HCP ROI equivalent.

Note: *It is the member's responsibility to obtain and provide copies of all civilian medical records to facilitate case processing. To assist with obtaining all records, it is recommended for the member to be provided a DD Form 2870 or HCP ROI equivalent to fill out/submit to each of their civilian providers so that their records can be submitted to the RMU.*

ii. Required documentation for LOD.

a. Proof of military status: AF Form 40A, Certified orders, UTAPS printout, MFR from Unit CC verifying status,

b. PCARS from MilPDS labeled "RSGRBTH" (Please refer to the Help tab in ECT for PowerPoint instructions)

c. Initial clinical note to match initial date of treatment

d. Historical/previous clinical notes on the same injury, illness, or disease

e. Any pertinent clinical documentation

f. OSI report, if applicable

g. DD Form 2910, if sexual assault case

h. LOD Medical Briefing.

i. AF Form 978, Mishap report, if warranted

j. Death certificate (if member is deceased)

k. Police report/Accident report for MVA.

l. MAP if applicable.

m. CED/NATO orders for deployment.

n. Pre/Post Deployment questionnaire, if applicable.

o. Member statement; signed and dated.

Note: *If you find that you need to add documentation to a case that is at the board level (AFRC/SGO or above) please email the documentation to the AFRC/SGO org box* AFRC.SGO.PhysicalStandards@us.af.mil *and request that it be added.* SUBJECT line should read: "ADDITIONAL DOCUMENTATION TO BE ADDED TO CASE (Add case number)".

B. Reinvestigation Request (RR) for LODs. These are for Formal LODs found NILOD and the member request to overturn the original finding. These requests are processed by the LOD PM.

i. RMU Process for Requesting RR.

a. This process is initiated by LOD PM via ECT.

b. LOD PM will be able to initiate a request after the LOD notification has been uploaded in ECT by the Unit CC

c. LOD PM will receive request from member no later than 45 days after notification.

d. LOD PM will review documentation submitted by member for new and substantial information.

ii. Required documentation for RR.

a. Request for reinvestigation

b. New substantiating documentation

C. Appeal of LOD. These are for informal LODs found NILOD and the member requests the original finding be changed. These requests are processed by the LOD PM (see DAFI 36-2910 for responsibilities).

i. Process for Requesting Appeal.

a. Initiated by LOD PM via ECT. (Please refer to the Help Tab in ECT for PowerPoint instructions)

b. LOD PM will be able initiate request after the LOD notification has been uploaded in ECT by the Unit CC. (Please refer to the Help Tab in ECT for PowerPoint instructions)

c. LOD PM will receive request from member no later than 30 days after notification.

d. LOD PM will review documentation submitted by member and upload in ECT

ii. Required documentation for AA.

a. Signed memorandum requesting appeal.

D. Initial Review in Lieu Of (IRILO). These cases are the initial review by AFRC/SGO for Non-Duty Disability Evaluation System (NDDES) or MEB packages. It allows for potentially returning a service member to duty who do not need full case adjudication. This process only applies to Reservists identified with potentially disqualifying medical or dental conditions IAW 48-123 and the Medical Standards Directory (MSD) retention standards. It is the initial look by AFRC/SGO and will be returned for either full case processing, returned without restrictions, or returned with restrictions (i.e., an ALC-C). AS noted below in **Section vi**. The IRILO phase can be bypassed at the discretion of the RMU AMRO for Non-Duty Disability Evaluation System (NDDES) cases.

i. RMU Process for Requesting IRILO.

a. IRILO cases will be initiated in ECT within 72 hours of placement, by the AMRO Board, of a member on an AAC 37. This will allow ECT to account for the time during which the case is prepared prior to submission, and if needed upon submission to SGO prioritizing older cases.

Note: *After priority 1 and 2 cases the 3rd level of priority for case processing is "age of case". The true age of a case is when member is placed on AAC 37, not when it was started in ECT. Initiating the case in ECT within 72 hours of the AAC placement will allow ECT to reflect (via the Case ID) true age of the case. This will allow case adjudication at AFRC/SGO, after working priority 1 and 2 cases (as flagged already in ECT), to then sort by Case ID to work "oldest case overall", not oldest case in the queue.*

ii. Required documentation for IRILO cases.

a. IRILO cover sheet.

b. Current AF Form 469 (reviewed IAW AFI 48-133).

c. Narrative Summary

d. Include pertinent documentation but do not make the reviewer dig through huge volumes of paperwork to find supporting documentation or to answer a question.

1. Initial/Final copy of diagnosis, PT notes, inpatient admission/discharge, and specialty consults, etc.

Note: *IRILO packages should not be delayed for pending LOD determinations. RMUs should submit IRILO packages when appropriate for all potentially disqualifying medical conditions and note in the narrative summary if a LOD determination is pending. If the member is found unfit based on IRILO package review and has a pending LOD disposition, the RMU will wait until the LOD determination is finalized (to include any applicable appeals) before proceeding to full case (NDDES or MEB) processing.*

E. Non-Duty Disability Evaluation System – (NDDES). These cases are for Non-Duty related disqualifying conditions after initial RILO has been returned as to the RMU adjudicated as "MEDICALLY DISQUALIFIED" with a direction to complete a full case for submission to the PEB. **RMU Commanders must ensure appropriate personnel are thoroughly familiar with the contents of this section.**

Note: *If the local AMRO decides that the member is not a good candidate for RTD, then the IRILO phase may be bypassed, and a full Non-Duty Disability Evaluation System (NDDES) may be completed first in lieu of the IRILO phase This process only applies to Reservists identified with potentially disqualifying* ***non-duty*** *related medical or dental conditions IAW DAFMAN 48-123 and the Medical Standards Directory (MSD) retention standards. Non-duty related is defined as not having been incurred or having been aggravated by military duty.*

i. RMU Responsibilities. RMU responsibilities will be accomplished when the Reservist is placed on AAC 37. Attachment 1-4 will be given to the member (either in person, email, or by mail) to cover the below information. NDDES cases will be initiated in ECT within 72 hours of placement, by the AMRO Board, of a member on an AAC 37. This will allow ECT to account for the time during which the case is prepared prior to submission, and if needed upon submission to SGO prioritizing older cases.

Note: *After priority 1 and 2 cases the 3rd level of priority for case processing is "age of case". The true age of a case is when member is placed on AAC 37, not when it was started in ECT. Initiating the case in ECT within 72 hours of the AAC placement will allow ECT to reflect (via the Case ID) true age of the case. This will allow case adjudication at AFRC/SGO, after working priority 1 and 2 cases (as flagged already in ECT), to then sort by Case ID to work "oldest case overall", not oldest case in the queue. It is not necessary for the RMU to make comments or upload documents until the case is ready to be submitted to AFRC/SGO for adjudication.*

a. Counsel the member on all medical aspects of the process and how the standards in DAFMAN 48-123 and MSD are used to determine the medical qualification for continued military duty. Any medical condition that is potentially disqualifying for continued military duty is reason for AFRC/SGO to perform Non-Duty Disability Evaluation System (NDDES) medical evaluation.

b. It is the member's responsibility to obtain and provide copies of all civilian medical records to facilitate case processing. To assist with obtaining all records, it is recommended for the member to be provided a DD Form 2870 to fill out/submit to each of their civilian providers so that their records can be submitted to the RMU.

Note: *It is recommended that RMUs ask SM to submit documentation via email or fax so that a time stamp of receipt can be obtained.*

c. AFI 48-133 describes the Commander's role in ensuring compliance of medical documentation.

d. Ensure the member understands that AFRC/SGO is not the final military authority that will determine the member's fitness for continued military duty. Depending on the choice the member will make when completing the Physical Evaluation Board (PEB) Election form, PEB will be the military authority who determines the member's fitness for continued military duty.

e. Explain to the member that their medical evaluation will be submitted to AFRC/SGO with or without the member's input at the end of the allotted time given to turn in medical documentation. If a SM does not turn in all requested items in the allotted time, they will be referred to their commander for non-compliance action.

f. Advise the member of the RMU point of contact (POC) and request his/her military and civilian contact information for the case.

ii. Notification of a Member's Non-Duty Disability Evaluation (NDDES) case.

a. Request for information letter (Attachment 7) will be given to the member. No alteration to this letter will be allowed.

b. Medical Disqualification for Military Duty Fact Sheet. This form is to notify the member and document proof of the briefing given to the member for a Non-Duty Disability Evaluation System (NDDES) case. (Attachment 1)

c. Medical Evaluation (ME) for Military Duty Fact Sheet. The ME Fact Sheet can be found in (Attachment 2).

d. PEB Fact Sheet (Attachment 3).

e. PEB Election Form (Attachment 4)

f. Certification of Refusal to sign form, if warranted (Attachment 6).

iii. Unit Commander's Memorandum (Attachment 5). Forward to the member's Commander via email.

a. The RMU will advise the unit Commander on all medical aspects of the member's case. The case will be submitted to HQ AFSC/SGO through the Electronic Case Tracking (ECT) system.

b. The RMU will refer the member to MPF/Personnel Relocation Element (DPMSA) for pre-separation briefing on their rights and options following a deployment limiting ALC action or "unfit" finding by Informal PEB/ Formal PEB when PEB is requested by member.

c. The RMU will send a request to the Unit CC for Commander Impact Statement (CIS) AF Form 1185.

iv. Postal Service Actions.

a. USPS Return for New Address: If the postal service returns the mail indicating an address correction, the RMU will resend the information to the member's new address via certified mail with return receipt requested. If the RMU has not received any communications from the member by the next UTA after placing them on an AAC 37, you will send the Notification package via certified mail.

b. If you utilize email correspondence to notify and/or send the documentation to the SM, and you do not receive or heard back by the next UTA, you will send it via certified mail.

c. USPS Return Undeliverable: If the postal service returns the mail as undeliverable (e.g., address is correct, but member refused receipt), then the RMU will resend the information to the member via first class mail. Allow the member a minimum of 60 days from the date of the first-class mail to respond. If the member doesn't respond within the allotted time, then the RMU will defer to the commander.

Note: *If you send documents through certified mail and the address is incorrect, it will be returned to sender and not forwarded to SM new address. For documents to be forwarded to SM new address, you would have to send via First Class mail. Recommend double checking SM address prior to sending.*

v. Cover Letter. Required for all ND-DES cases submitted to AFRC/SGO (Attachment 8). Please include all disqualifying condition(s) and MSD references that apply.

vi. Commander Impact Statement AF Form 1185 (CIS): The RMU will send a request to the Unit CC directly for CIS completion (providing the most current template from e-publishing), along with guidance for the Unit CC to fill out the form as part of a discussion with the member prior to COB the following UTA. MPF is not involved in CIS completion, and the Wing CC input is not required. The Unit CC will fill out/sign the form and obtain the member's signature before returning the form to the RMU. If the member refuses to sign, the commander will annotate "member refused to sign" in the member's signature block and return the form to the RMU if warranted. Q1-Q6 of the AF Form 1185 can assist in verifying if the member's condition is service connected. If Commander states yes, service connection should be verified and documented in the case.

vii. A minimum of 60 days (from the date member was notified of the MR DLC action) must elapse before the RMU will submit a case to HQ AFRC/SGO. A case submitted earlier than the minimum 60-day period must include the CIS and statement from the member (signed and dated) indicating he/she has waived the minimum 60-day period.

viii. Documentation. Review all available hard copy and electronic medical records (composite STR, AHLTA, HAIMS, JLV, MHS-Genesis, etc.). Include pertinent documentation but don't make the reviewer dig through huge volumes of paperwork to find supporting documentation or to answer a question.

a. Initial/Final copy of diagnosis, PT notes, inpatient admission/discharge, and specialty consults, etc.

ix. Accompanying Documents. The following documents are included in the reports forwarded to HQ AFRC/SGO for review via the ECT system.

a. Narrative Summary (no older than 6 months). See AFPC Medical Retention Standards website for templates.

1. NARSUMs will only be signed by privileged military medical providers. For Non-Duty Disability Evaluation System (NDDES), MH NARSUMs reference chapter 24.

b. Non-Duty Disability Evaluation System (NDDES) Cover letter (MFR) - please include all disqualifying condition(s) and MSD references that apply.

c. HQ AFRC/SGO provided - disqualification letter (Reserve only)

d. IRILO Coversheet "DQ Letter in IRILO case" (optional)

e. CIS- Commander Impact Statement (no older than 6 months)

f. Unit CC Memo

g. Current AF Form 469 - not expired (no older than 1 year), not a working copy

h. Civilian and military medical and dental documentation relevant to the case, i.e., must include pertinent past history and most current medical documentation for active diagnosis (ex. clinical notes, diagnostic results, etc.).

i. PEB fact sheet

j. ME fact sheet

F. Mental Health Narrative Summary. See Chapter 24.

G. Medical Evaluation Board (MEB). These cases are for duty related disqualifying conditions after IRILO disqualification. This process only applies to Reservists identified with potentially disqualifying duty related medical or dental conditions IAW DAFMAN 48-123 and the Medical Standards Directory (MSD) retention standards. AFRC/SGO utilizes this workflow to track cases as they progress through MEB/IDES and PEB steps. RMUs do not utilize this workflow, contact MTF PEBLO for status.

Note: *If there are multiple potentially disqualifying conditions and at least one has an ILOD then all conditions will be submitted for MEB review.*

i. RMU Process for Requesting MEB. (For information only)

a. These are cases for AGR members and/or members with service-connected disqualifying conditions.

b. Case will be initiated by AFRC/SGO technicians, NOT RMUs.

c. If cases are overturned by PEB the RME memo will be uploaded in the workflow and the RMU will be able to retrieve it from ECT. The PEBLOs will also be notified by AFRC/SGO.

H. Medical Hold. AFRC/SGO is the approving authority for retaining a member for DES medical issues beyond an established separation or retirement date. (DAFMAN 48-108 and DoDI 1332.38). SM may choose to extend their service commitment up to 24 months but cannot be made to do so. Those members going through a MEB IDES process with the AD MTF may opt out of Medical Hold if they do not want to go through the MEB process. See PEBLO for details.

i. Medical Holds are for members with both:

a. Less than 60 days of MSD/HYTD/DOS, and

b. A military related DQ condition(s).

ii. Medical Holds are NOT for:

a. Evaluating or treating chronic conditions.

b. Performing diagnostic studies.

c. Elective treatment of remedial defect.

d. Non-emergent surgery or its convalescence.

e. Civilian employment issues.

f. Preservation of terminal leave.

g. Any other condition which does not warrant termination of active duty.

h. SM going through ND-DES processing.

iii. Separation or retirement processing continues until medical hold is approved.

a. Medical Hold does not apply to Expiration of Time in Service (ETS) cases.
b. Medical Hold Examples:

1. Acute condition for which member is expected to fully recover and not require MEB processing – No Med Hold

2. Acute condition that overcomes presumption of fitness and will result in disability even after surgical correction - Med Hold Appropriate

3. Chronic condition but member has been able to do their job despite problem, does not overcome presumption of fitness – No Med Hold

4. Chronic condition – that has interfered with duty since before applying of retirement or in last year, may overcome presumption of fitness – Med Hold appropriate

c. Medical Hold Requests process – Requesting provider should have the following info:

1. Date of projected separation or retirement.

2. Whether Initial RILO processing has been initiated, and if so, the estimated time until the Initial RILO package will be ready for submission to HQ AFRC/SG.

3. Whether administrative separation or Court Martial charges are pending.

4. Servicing Military Personnel Section (MPS) implementing separation or retirement.

5. Whether SM desires to be retained in duty status for disability processing.

6. Member's AFSC.

7. Confirmation that the PEBLO and either the SGH or SGP have been notified of the providers' intent to request Medical Hold.

iv. RMU Process for Requesting Medical Hold.

a. Determine if member is 60 days within separation or retirement.

b. Determine if the member is undergoing a LOD or IDES processing.

c. Notify your local FSS.

v. Required documentation for Medical Hold.

a. Orders verifying separation or retirement date.

b. IRILO submitted in ECT or LOD with disqualifying condition.

c. AF Form 469.

d. Medical Hold request stating member is requesting retention for case processing.

Note: *See AFRC/SGO folder on the KX for template.*

I. Retention Waiver Renewal (RW). These cases are the interim review by AFRC/SGO for members who have previously been through Non-Duty Disability Evaluation System (NDDES), I-RILO, or MEB/IDES processing and were returned to duty in some capacity. It allows for expedited return of service members who do not need full case adjudication. It is a follow up look by AFRC/SGO and will be returned for either full case processing, returned without restrictions (no ALC-C), or returned with restrictions (i.e., an ALC-C).

i. RMU Process for Requesting RW.

a. Ensure AF469 is current. For expired RW see Chapter 7 for appropriate verbiage.

b. Notify member to provide yearly clinical notes 6 months prior to Renewal due date.

c. Have provider review clinical notes for any changes in condition(s).

d. If a new potentially disqualifying condition is found prior to submitting RW, a new case will be required (with member being placed on AAC 37) and must include all new and previous adjudicated conditions.

Note: *Case is no longer considered a Renewal if the above applies and must be submitted as a new IRILO or NDDES package.*

e. If requesting a reduction or removal of ALC-code, complete a full NARSUM and provide recent clinical notes. If condition has worsened, provide full NARSUM.

f. Submit prior to renewal expiration date stated on Report of Medical Evaluation (RME) memo from AFRC.
g. Clinical notes provided with the RW case must specifically mention status of condition being reviewed and be relevant.

Note: *Do not simply submit a copy of the member's annual physical, without it being able to mention the condition and provide an adequate assessment of member's stability with said condition.*

ii. Required documentation for RW cases.

a. For stable conditions use A-RILO worksheet or NARSUM.

b. If you include clinical documentation only, include pertinent documentation but do not make the reviewer dig through huge volumes of paperwork to find supporting documentation or to answer a question.

1. Initial/Final copy of diagnosis, PT notes, inpatient admission/discharge, and specialty consults, etc.

c. Report of Medical Evaluation memo

d. Duty Limiting Condition Report, if applicable

J. Deployment Waiver (DW). These cases will be used for those members who require a waiver to deploy. This includes those on an ALC C1, C2, or C3, any Deployable With profiles (refer to MSD), and those who need approval by COCOM specific reporting instructions. Generally, these will have CED orders for a named operation/deployment. AFRC/SGO will review the case, then, if approved, the case is forwarded to gaining COCOM for final disposition. Reference the following website to ensure all required items are accomplished prior to submission and for COCOM specific guidance.

Note: *All deployment waivers are required to go through AFRC at the request of the COCOM/SG for continuity and accuracy.*

a. AEF Online

ii. RMU Process for Requesting DW.

a. RMU verify deployment location from ASIMS deployment module or UDM and cleared by Wing CC.

b. Ensure all required items are accomplished prior to submission and for COCOM specific guidance.
c. Do not submit DW any earlier than 120 days of deployment, but no later than 75 days.

d. RMU verify ASIMS IMR is up to date.

e. Ensure Flying, SOD, and retention waivers are current throughout deployment. Submit early RW or AMS, as necessary.

f. Any short notice deployments need to be annotated in comments.

iii. Documentation Required for Deployment Waiver.

a. Receiving MAJCOM template and any documentation required.

Note: *DO NOT alter MAJCOM documents.*

b. Report of Medical Evaluation RTD letter from AFRC/SGO.

c. Current medical documentation to verify any changes in condition or verify continued stability.

d. Current AF Form 469 and AF Form 422, if applicable.

K. Modification Waiver (MO). These cases are for those members on an ALC-C3 who need a temporary (time limited) deviation from the enumerated restrictions on the return to duty letter. These will be for CONUS only and include such items as attendance at formal schools, TDY, training, field exercises, etc. No permanent modifications to an ALC will occur during modification processing. Modification waivers will be considered on a case-by-case basis.

Note: *Pay close attention to verbiage on Report of Medical Evaluation (RTD letter); restrictions may vary at AFRC/SGO discretion.*

i. RMU Process for Requesting MO.

a. Receive request for MO from member's Commander.

b. Review EHR/STR for any changes in medical status.

c. Initiate/track case in ECT.

ii. Required documentation for MO.

a. Report of Medical Evaluation letter (cannot expire while member is performing duty)

b. A summary of member's condition addressing the diagnosis and referencing the Medical Standards Directory (MSD), current medication(s), current duty/fitness restriction, prognosis, duration of modification, follow-up requirements, and privilege military provider signature. The privileged military provider should include an assessment of the stability of the condition, any need for clinical follow-up or testing, and the impact of the condition upon the member's duty performance.

c. All pertinent clinical records. Keep in mind that not every single piece of paper needs to be uploaded. "Pertinent" refers to initial exams, certain follow ups that show a change in status, and a final evaluation.

Note: *For example, Physical Therapy notes sent can be the initial evaluation and the final evaluation, if it shows the SM's progress, good or bad.*

d. Current AF Form 469.

e. Modification Request Letter from member's Commander: Commander will justify why this member is critical for the formal schools, TDY, training, field exercises, etc. The letter should also include a requested duration and location; to include travel dates if accruable.

f. Input dates/location/purpose/travel requirements (HOR to location via car/plane/etc.) under justification Section of ECT to include travel days.

L. Non-Emergent Surgery Request. RMUs will process non-emergent surgery requests for those SM on long-term orders, to include, ADOS, MPA, etc., prior to the final six months of service. Active Duty MTFs should contact the appropriate Reserve SGP when members may require surgery.

i. Surgeries that do not save life, limb or eyesight are considered non-emergent. While cosmetic surgeries are certainly non-emergent, they are not the only non-emergent surgeries.

a. Does not mean the surgery would be inappropriate

b. Does not apply to cosmetic surgeries only

c. AFRC/SGO is the approval authority for members within 6 months of separation or end of active-duty orders

d. Requested in ECT under Non-Emergent Surgery

e. Approval will be contingent on member's signed understanding that separation date or orders will not be adjusted for convalescence or complications.

f. NARSUM from provider conducting non-emergent surgery must have the following information:

1. Type of surgery

2. Restrictions

3. Recovery period

Note: *If member is not within six months of separation, do not submit the request.*

ii. RMU Process for Requesting NE.

a. Ensure member is within 6 months of separation/retirement.

b. Verify if member would qualify for Medical Hold.

iii. Required documentation for NE.

a. NE request form.

b. Pre-Op notes.

c. Orders validating member is within 6 months of separation.

d. NARSUM to include type of surgery, recovery time, and restrictions.

e. Member signed understanding memorandum. Template can be located in the SGO Folder on the KX.

Attachment 1
Medical Disqualification for Military Duty Fact Sheet

1. I understand that I have a medical condition, which is medically disqualifying for worldwide duty for over thirty days and requires that I be placed on an Assignment Availability Code (AAC) 37.
2. I understand that while on an AAC 37 I am considered medically disqualified for worldwide duty and will be placed on a limited participation status until after the AAC 37 has been removed.
3. I understand that my Commander will make a participation determination based on input from the medical unit and may implement restrictions on my participation. This may include being restricted from performing any military duty for pay or points.
4. I understand that I have _____ days (**minimum 60**) to provide the **{name RMU}** with medical information from my treating healthcare provider(s) to be included in my case file. I understand that AFRC/SGO must review my case to determine if I am medically qualified for restricted or worldwide duty.
5. I understand that refusal to provide requested information may result in administrative action to include separation.
6. I understand that a medical disqualification action by AFRC/SGO is not the final action to determine whether I may remain in the Air Force Reserve.
7. I understand that if AFRC/SGO determines that I am not medically qualified for worldwide duty for over one year, a Physical Evaluation Board process will determine whether I may remain in the AF Reserve.
8. I understand that I will be separately advised in writing if found medically disqualified for a period likely to exceed one year and that I will be advised of my rights and obligations under the PEB process at that time.

_____	_____	_____
Signature of Member	**Printed Name**	**Date**
_____	_____	_____
Signature of Briefer	**Printed Name**	**Date**

Member refused to sign this Fact Sheet. I certify that I verbally briefed him/her on each of the paragraphs above on _____.
Date

_____	_____	_____
Signature of Briefer	**Printed Name**	**Date**

ALTERATIONS RENDER THIS FORM VOID

Attachment 2
Medical Evaluation (ME) for Military Duty Fact Sheet

_____1. I understand that I have a medical condition which is medically disqualifying for worldwide duty and requires that I be placed on an Assignment Availability Code (AAC) 37.
_____2. I understand that while on an AAC 37 I am considered medically disqualified for worldwide duty and will be placed on a limited participation status until after the AAC 37 has been removed.
_____3. I understand that the **{name RMU}** must prepare a medical evaluation package on me to forward to AFRC/SGO for their review to determine if I am medically qualified for worldwide duty.
_____4. I understand that I have _____ days **(minimum of 60 days)** to provide the **{name RMU}** with medical information from my treating healthcare provider(s) to be included in my case file.
_____5. I understand that my case will be forwarded to AFRC/SGO without this information if I do not provide it to the **{name RMU}** within the allotted time. If it is determined that the case is insufficient to make a fitness determination and I fail to provide sufficient documentation/information, I will be forwarded to my Commander for non-compliance and be subject to administrative action.
_____6. I understand that AFRC/SGO must review my case to determine if I am medically qualified for worldwide duty.
_____7. I understand that a medical disqualification action by AFRC/SGO is not the final action to determine whether I may remain in the Air Force Reserve.
_____8. I understand that if AFRC/SGO determines that I am not medically qualified for worldwide duty, the Physical Evaluation Board (PEB) process will determine whether I may remain in the Air Force Reserve. If I do not elect to have my case forwarded to the PEB, the decision by AFRC/SGO is final and my case will be forwarded to ARPC for separation action. I further understand that if found "medically disqualified" by AFRC/SGO and retained in the Air Force Reserve, after being found "fit" by PEB, my continued participation in the Air Force Reserve will be in a restricted status.
_____9. I understand that if not approved for retention in the Air Force Reserve because of a medically disqualifying non-duty related medical/dental condition(s), I am eligible to have my case reviewed by the PEB solely for a fitness determination. By completing and signing the "PEB Election Form," I am making my election to have or to not have my case reviewed by the PEB.
_____10. I understand that I must directly report to **{name MPF, Personnel Relocation Element}** to receive a pre-separation briefing. At a minimum, this briefing will advise me of out-processing requirements and my eligibility or ineligibility for retirement in lieu of separation in the event I am separated or elect retirement (if eligible) in lieu of separation, based on physical disqualification.
_____11. I understand that I am NOT being separated at this time and am only being placed on a limited participation status pending case processing.

_____	_____	_____
Signature of Member	**Printed Name**	**Date**

I have nothing further to submit for consideration and waive the minimum 60-day period. I want my case processed as soon as possible. (I understand that if the RMU or HQ AFRC/SGO finds there is insufficient documentation to make a fitness determination and I refuse to provide additional information/documentation, I will be forwarded to my Commander for non-compliance.)

_____	_____	_____
Signature of Member	**Printed Name**	**Date**

ALTERATIONS RENDER THIS FORM VOID

Attachment 3
Physical Evaluation Board (PEB) Fact Sheet

Any member of the Ready Reserve who is not called to active duty for more than 30 days and who is pending separation for impairments unrelated to the member's military status and performance of duty, shall have the opportunity to have his/her case reviewed by the PEB **solely for a fitness determination** upon the request of the member. The sole standard to be used in making a determination of unfitness due to physical disability shall be unfitness to perform the duties of the member's office, grade, rank or rating because of disease or injury.

There are two PEBs; an Informal PEB (IPEB) and a Formal PEB (FPEB), both located at Randolph AFB TX. The PEBs are a fact-finding body that investigates the nature, origin, degree of impairment, and probable permanence of the physical or mental defect or condition of any member whose case it evaluates to determine if a member is fit or unfit for continued military service. The IPEB is the first board and is followed by the FPEB, if the member rebuts an unfit determination by the IPEB. The member may rebut an "unfit" determination and in some instances a "fit" finding as well.

The IPEB reviews appropriate medical and personnel records and related documentation to determine fitness for duty. Neither the member nor counsel may be present at the informal hearing. If a member disagrees with the recommendation of the IPEB and requests a FPEB hearing, the member will submit a brief rebuttal stating reason for disagreement.

The FPEB provides members recommended for discharge or retirement the opportunity to appear in person before the FPEB, to be represented by an appointed military counsel or counsel of their choice, and to present evidence and call witnesses. **Members of the Ready Reserve are responsible for their personal travel and other expenses (including non-DOD legal counsel)**. Hearings are not adversarial; they are administrative in nature. The FPEB reviews appropriate medical and personnel records and related documentation, considers evidence and testimony by witnesses, and determines member's fitness for duty. All decisions by the FPEB are final, and the member has no right to rebuttal.

I hereby certify that I received a copy of this Fact Sheet.

_____	_____	_____
Signature of Member	**Printed Name**	**Date**

ALTERATIONS RENDER THIS FORM VOID

Attachment 4
Physical Evaluation Board (PEB) Election Form

_____ 1. I understand that I may request my case be forwarded to the PEB for review in the event that I am medically disqualified for worldwide duty by AFRC/SGO. The review by the PEB is only to determine my "fitness" for continued military duty and not to determine if I am entitled to disability processing. By completing and signing this form, I am making my selection for PEB review.

_____ 2. If I elect to have my case reviewed by the PEB solely for a "fitness" determination, I understand referral of my case does not constitute a disability evaluation, and an "unfit" decision does not entitle me to disability compensation from the Air Force.

_____ 3. I understand that I have no right to rebuttal on any "unfit" decisions made by the FPEB. I understand that a "fit" determination may not be rebutted.

_____ 4. I further understand that if I am medically disqualified for worldwide duty by AFRC/SGO and I am found "fit" by the PEB and returned to duty, my continued participation in the Air Force Reserve will be in a restricted status. RMU/SGP will place restrictions on my participation which are appropriate for the type of medical condition(s) I have.

5. **My PEB selection is indicated below:**

_____ Yes, I desire to have my non-duty related, medical disqualification case referred to the IPEB solely for a fitness determination. I understand I can submit a statement for consideration by the PEB.

_____ No, I do not desire to have my case referred to the IPEB. I understand, in the event that AFRC/SGO determines I am medically disqualified for worldwide duty I will be processed for involuntary separation without my case being reviewed by the PEB. If eligible for retirement, I understand I will be afforded the opportunity to apply for retirement in lieu of separation.

_____ _____ _____
Signature of Member **Printed Name** **Date**

To facilitate timely and accurate notification of IPEB results, I understand that I must immediately notify my servicing Reserve Medical Unit and Military Personnel in the event my mailing address changes. My current mailing address and telephone number are as follows:

Printed Name: _____ Mailing Address: _____
_____
_____

Telephone Number: (_____) _____ - _____

ALTERATIONS RENDER THIS FORM VOID

Attachment 5
Unit Commander Memorandum Template

{DATE}

MEMORANDUM FOR **{member's immediate Commander}**

FROM: **{name of RMU}**/CC

SUBJECT: Notification of Medically Disqualifying Condition

1. Our records indicate that **{member's name & Last4 SSN}** has been found to have a medical condition which does not meet medical standards in DAFMAN 48-123, *Medical Examination and Standards*. Subject member has been placed on an Assignment Availability Code (AAC) "37" pending a fitness for duty evaluation. A participation determination should be made by you in consideration of the duty restrictions communicated by the **(RMU)** via the member's AF Form 469.

2. We will evaluate **{member's name}** medical condition and prepare a case for submission to HQ AFRC/SGO for their review and disposition. The member has been given **{number of days}** days to provide us with any medical documentation from their private healthcare provider which they may want the Air Force Reserve Command Surgeon to consider.

3. If the member is found medically disqualified for worldwide duty and declines Physical Evaluation Board (PEB) review, HQ AFRC/SGO will forward the case to ARPC/DPTTS for separation processing.

4. If the member is retained, appropriate disposition instructions will be forwarded to us by HQ AFRC/SGO. We will relay this information to you, the member, and the MPF/Personnel Employment Element via issuance of a new AF Form 469 and AF Form 422. If the decision is to not retain the member and the member has requested review by the PEB, the case will be forwarded to ARPC/DPTTS for submission to the PEB. The PEB will make a "fitness" determination only.

5. If the member is found medically disqualified for worldwide duty but retained or found "fit" for duty by the PEB, the member will be placed in an Assignment Limitation Code (ALC) "C" status by AFRC/SGO.

6. We have briefed this member on the medical aspects of this process, and they are directed to report to the MPF/Personnel Relocation Element for a pre-separation briefing.

7. The MPF has been notified of this action. The MPF/Personnel Relocation Element will advise the member of out-processing requirements and his/her eligibility for retirement in lieu of separation in the event the member is processed for separation.

8. If you have any questions, please contact my POC {**name/phone number**}.

{RMU/CC's digital or wet signature required}
{SIGNATURE BLOCK}

cc: **{member's name}**
{name MPF}/Personnel Employment Element

Attachment 6
Certification of Refusal to Sign

To be used for Military Duty Fact Sheet and PEB Fact Sheet.
(Initial and date any actual refusals below)

Member's Name: _____

SSAN: _____

_____ Member refused to sign Medical Evaluation for Military Duty Fact Sheet but was provided a personal copy on (date) _____.

_____ Member refused to sign Physical Evaluation Board (PEB) Fact Sheet but was provided a personal copy on (date) _____.

_____	_____	_____
Signature of Briefer	**Printed Name**	**Date**

Attachment 7
Request for Medical Information

{DATE}

MEMORANDUM FOR **{name of RMU}**

FROM: **{Civilian Provider's information}**

SUBJECT: Request for Medical Information: **{Member's name, last four SSN}**

1. PRIVACY ACT STATEMENT. Authority: Title 10, U.S.C., Sections 10204 and 10205, and E. O. 9397. Principle Purpose: To maintain essential records of Air Force Reservists and identify specific personal capabilities. Routine Uses: Disclosure may be made to any Department of Defense component or, upon request, to other Federal, state, or local agencies in pursuit of their official duties and may be used for other lawful purposes including law enforcement and litigation. Disclosure: MANDATORY. Failure to respond could cause incorrect priority for recall in the event of national mobilization and is a violation of Federal law.

2. COMPLETE MEDICAL HISTORY OF THE CONDITION.

_____
_____
_____
_____

3. DIAGNOSIS (Include ICD 10 Code)

_____
_____

4. TREATMENT PLAN.

_____
_____
_____

5. LIMITATIONS (Include social and industrial impairments [S&I] for psychiatric conditions. If no limitations, state so.)

_____
_____

Check specific military-related activities the member **CANNOT** perform.

____Run 1.5 Mile
____Abdominal Crunches
____Maximum effort 100-yard run
____Push-ups
____High Impact Activities

____Bend, crawl, stoop, climb, etc.
____Stand ≥12 hrs.
____Walk 2 kilometers/1.25 mi
____Carry, drag, lift, push, & pull ≥40lbs

ANTICIPATED RELEASE DATE _____

6. RECOMMENDATION OF THE PATIENT'S ABILITY TO PERFORM DUTIES IN A STRESSFUL AND PHYSICALLY DEMANDING ENVIRONMENT.

_____
_____
_____

7. CONFIRMATORY DATA: Please attach all clinical/treatment notes, results of any imaging studies, laboratory, additional testing, consultations, or other data which substantiate the information on this form regarding the diagnosis or limitations. DO NOT submit letters, patient handouts, or memos.

_____ _____ _____
Physician's Name and Title (Type or Print) Signature Date

Attachment 8
NON-DUTY DISABILITY EVALUATION SYSTEM (NDDES) COVER LETTER

{DATE}

MEMORANDUM FOR: AFRC/SGO

FROM: {**RMU NAME}**

SUBJECT: NON-DUTY DISABILITY EVALUATION SYSTEM (NDDES) FOR **{MEMBER RANK, NAME, & SSN}**

1. {MEMBER RANK, NAME} is undergoing a Non-Duty Disability Evaluation System (NDDES) for **{list condition(s), MSD and/or DAFMAN 48-123 references}.**

2. For questions please contact **{RMU POC Rank and Name}** at Comm: **{###-###-####}, DSN {###-###-####}** or via email at **{address}.**

{RMU/CC's digital or wet signature required}
{SIGNATURE BLOCK}

ATTACHMENT 9
NON-COMPLIANCE MEMORANDUM FOR RECORD

{DATE}

MEMORANDUM FOR: **{UNIT}**/CC

FROM: **{name RMU}**/CC

SUBJECT: Non-Compliance Notification of **{MEMBER'S RANK, NAME, SSN}**

1. Our records indicate subject member has medical/dental requirements that have not been completed or have expired.

a. IAW DAFMAN 48-123, Para 9.13.5.1. Refusal. A member of the ARC with a known medical or dental condition who refuses to comply with a request for medical information or evaluation is considered medically unfit for continued military duty and is referred to their immediate commander for processing IAW AFI 36-3209. Reservists or Guardsmen who fail to provide documents or appear for scheduled appointments are non-compliant and will be referred to their commander in writing for administrative separation IAW AFI 36-3209.

b. IAW DAFMAN 48-123, Para 9.13.5.2. Noncompliance. Reservists or Guardsmen who fail to provide documents or appear for scheduled appointments are non-compliant and will be referred to their Commander in writing for administrative separation in accordance with AFI 36-3209.

2. For MPF: Update Duty Status (DS) Code to 14.

{RMU/CC's digital or wet signature required}
{SIGNATURE BLOCK}

cc: **{member's name}**
{name MPF}

ATTACHMENT 10
COMPLIANCE NOTIFICATION MFR

{DATE}

MEMORANDUM FOR: **{UNIT}**/CC

FROM: **{name RMU}**/CC

SUBJECT: COMPLIANCE OF **{MEMBER'S RANK, NAME, SSN}**

1. Our records indicate that subject member has complied with all medical/dental requirements and may now participate for pay and points activities IAW AFMAN 36-2136, Reserve Personnel Participation.

2. For MPF: Update Duty Status (DS) Code to 00.

{RMU/CC's digital or wet signature required}
{SIGNATURE BLOCK}

cc: **{member's name}**
{name MPF}

ATTACHMENT 11
HIV Initial Notification Memorandum Template

{Date}

MEMORANDUM FOR **{MEMBER'S NAME}**

FROM: {***NAME RMU***}

SUBJECT: Notification to Return to {***NAME RMU***}

1. We request that you return to the {***NAME RMU***} to discuss the results of your previous laboratory tests that were taken in conjunction with your periodic physical examination. These results may have revealed a medical condition of a personal nature. It is important that you contact this facility within the next 10 days for an appointment to discuss your lab results.

2. Your Commander has been informed of this request for you to return to the medical facility. He may contact you to arrange an appointment with the medical facility. It must be emphasized that since he is not a physician, he cannot provide specific details of the lab results to you.

3. I must reemphasize that it is extremely important that you contact this facility within 10 days for an appointment to discuss your lab results.

{HIV Designated Physician Sig Block}

cc: **Member's Commander**

Note: *This letter must be sent via registered mail, address correction requested. The outside of the envelope will be stamped "Personal - To Be Opened by Addressee ONLY." The memorandum itself will be enclosed in a smaller envelope inside the larger envelope. The smaller envelope will also have the addressee's name printed on the outside and stamped: "Personal - To be opened by* ***{MEMBER'S NAME}*** *only."*

ATTACHMENT 12
HIV Commander Notification Memorandum Template

{Date}

MEMORANDUM FOR **{Unit}**/CC

FROM: {***NAME RMU***}

SUBJECT: Notification to Return to {***NAME RMU***}

1. {Member's Name} of your unit has tested positive for the HIV antibody. **{He/She}** has been sent the attached letter requesting that **{He/She}** return to this facility to discuss the results of the laboratory test taken in conjunction with **{He/She}** periodic physical exam. It is extremely important that **{He/She}** contacts us as soon as possible and arrange for additional follow-up.

2. We request your assistance in scheduling the member's return to the medical unit. **(Gender)** has not been told of testing positive for the HIV antibody. That will be done face to face at the time of his appointment with this facility. Do not discuss any of this information with the member.

3. As the Commander, you must decide as to whether the member can be retained in the Selected Reserve. Contact your supporting MPF chief for further guidance on making this determination. Please mark the appropriate box below with your decision and return this form to this facility prior to the member's appointment.

4. HQ AFRC policy requires that this information be provided to the wing/CC and you, the member's immediate Commander. This information must be held in the strictest confidence. **The medical information in this memorandum is privileged and should not be divulged to unauthorized persons.**

{RMU/CC's digital or wet signature required}
{SIGNATURE BLOCK}

1 Attachment:
Member's memorandum (First Notification)

{Date}

1st Ind, **{Unit}**/CC

Memorandum For {***NAME RMU***}

I **will/will not** retain subject member.

{Unit/CC's digital or wet signature required}
{SIGNATURE BLOCK}

Note: *This memorandum is used for notification of member's Commander. Enclose it in an envelope stamped "**Eyes Only (Unit Commander)**."*

ATTACHMENT 13
HIV Second Notification Memorandum Template

{Date}

MEMORANDUM FOR **{MEMBER'S NAME}**

FROM: {***NAME RMU***}

SUBJECT: Notification to Return to {***NAME RMU***}

1. The results of your laboratory test (HIV Test) taken during your periodic physical examination shows that there is a substance called an antibody to the Human Immunodeficiency Virus, commonly known as HIV, present in your blood.

2. I am sure this information raises concerns about your health. The only thing the test tells us is that you may have evidence of past contact with the virus which is believed to be capable of causing Acquired Immune Deficiency Syndrome, which is usually called AIDS. I am not telling you that you have AIDS. I want to be very clear on that point. The only thing the test tells us is that you may have evidence of past contact with the virus.

3. Your Commander has been informed of the request for you to return to the medical facility and that you require further evaluation. He/she may contact you to arrange an appointment with the medical facility. It must be emphasized that since he/she is not a physician, he/she cannot provide specific details of the lab results to you.

4. You should immediately contact your civilian healthcare provider for appropriate counseling, evaluation, and treatment if necessary. Your civilian healthcare provider must know that your blood sample tested ELISA (enzyme-linked immunosorbent assay) positive with positive Western Blot confirmation.

5. If you fail to contact the (**name RMU**) within 15 days, or you fail to report for the appointment to discuss your lab results, your case will be referred to your Commander for appropriate administrative action. I want to emphasize that it is extremely important that you seek professional medical advice and guidance from your physician or clinic to get the proper evaluation as soon as possible.

{RMU/CC's digital or wet signature required}
{SIGNATURE BLOCK}

1 Attachment:
HIV Fact Sheet

Note: *This second memorandum is used only if the member does not respond to the initial notification memorandum. It must be an individually typed original, signed by the RMU Commander, and sent via registered mail; address correction requested. The outside of the envelope will be stamped "Personal - To Be Opened by Addressee Only." The letter itself will be enclosed in a smaller envelope inside the larger envelope. The smaller envelope will also have the addressee's name, printed on the outside and stamped "Personal - To Be Opened by* ***{MEMBER'S NAME}*** *Only."*

ATTACHMENT 14
AFRC Conventions for CCQAS

1. Provider Demographics Screen: Branch is F-12. When adding a provider and asked for provider type use the term "DDR-drilling ready reservist. AFSC is the duty AFSC that the person is assigned to. Use the individuals address and contact information, not the units. For work center put down the individual's squadron of assignment using short nomenclature (example: 926 MDS). Department Code should be left blank.

2. Provider Specialty Screen: All specialties that the individual has should be reflected on this page whether they apply for privileges or not. Level of training must be specified. Level of training should normally be board certified or board eligible. If an individual has finished a residency but is not board eligible, use fully trained. Flight Surgeons should be listed as having the specialty of Aerospace Medicine (not Aviation Medicine) and should be given the training level of fully trained based on their AMP course attendance.

3. Professional Education Screen: All degrees should be added in addition to the qualifying degree (MD, DDS, and DO). All internships and residencies should be added under other education. Do not use the PGY labels for individuals who have completed residency, just use the residency label.

4. Additional Training Screen: Fill in all applicable training fields such as C4, BLS, etc. Also use the "add additional training" to track CME. Do not enter other training information that is otherwise tracked in MRDSS.

5. Affiliation Screen: When adding affiliations, enter all civilian places of employment using the "facility" button. Off duty employment is not applicable and will not be used.

6. Readiness Screen: Ensure the members UTC is put in the UIC/UTC field. Although not deployable, Non-Duty Disability Evaluation System (NDDES) AE is considered a valid UTC for this data field. Under Commander's annual SMRT verification put the most recent attendance at Sheppard field training, C-Stars, Top Star, or equivalent training. The AOC AFSC should match the duty AFSC that was previously entered in the demographics page. Mobilization Specialties must include, at least, their duty AFSC specialty. If they want to consider themselves available for other specialties they may have additional mobilization specialties assigned but must maintain sustainment and other training requirements for the additional AFSCs. These mobilization specialties should always be specialties that are listed at the bottom of the page (see number 2 above).

7. NPDB/etc. page: Under "adverse information on file" use only the "yes" or "no" buttons. Do not use "no, but previously was yes" button.

8. Provider Photo Screen: Because of the mobile nature of Reservist providers a digital photo is required for upload into this page.

ATTACHMENT 15
NOTIFICATION OF FFD CASE DEFERMENT

{DATE}

MEMORANDUM FOR: **{UNIT}**/CC

FROM: **{name RMU}**/CC

SUBJECT: DEFERMENT OF FFD CASE **{MEMBER'S RANK, NAME, SSN}**

1. Our records indicate that subject member **{RANK, NAME}** has been given 120 days to provide pertinent medical records in support of the required Fitness for Duty assessment and has not complied with these requests. No further action can be taken at this time by **{XXXRMUXXX}**. The AF Form 469, AAC 37 will be maintained current while the member remains in service.

2. Recommend appropriate administrative action be taken to either ensure member compliance or administratively separate service member. Absent required medical records no action to resolve member mobility restricted status can occur.

{RMU/CC's digital or wet signature required}
{SIGNATURE BLOCK}

cc: **{member's name}**
2 attachments:
{Documentation sent to subject member}
(Previous non-compliance memos sent to unit}

Attachment 16
Public Health Emergency Officer Appointment Letter

{Date}

MEMORANDUM FOR HQ AFRC/SG
HQ AFRC/SGO

FROM: **Wing CC**

SUBJECT: Letter of Appointment for Installation Public Health Emergency Officer (PHEO)

1. IAW AFI 10-2519, Para, 2.3.1.4., *Public Health Emergencies and Incidents of Public Health Concern* (26 June 2015), this letter appoints the following personnel to the positions listed:

Position	**Rank**	**Name**	**Office Symbol**	**DSN Duty Phone**
Primary				
Alternate				

2. The PHEO role is critical in preparation and response to a public health emergency or incident of concern and functions as a direct medical advisor to installation leadership. Further guidance is outlined in AFI 10-250, *Air Force Emergency Management (EM) Program*, and AFMAN 10-2608, *Disease Containment.*

3. For questions, please contact **{RMU POC Rank & Name}** at Comm: **{###-###-####)**, DSN **{###-####}** or via email at **{address}**.

Wing Commander Name, Rank, USAF
Commander

Attachment 17
LETTER TO MEMBER'S SUPERVISOR

1. Subject member may participate in a restricted status while pregnant (see attached AF Form
469) unless restricted earlier by a military physician. She may participate until (enter date; her 34th week of pregnancy) or volunteer to participate IAW AFMAN 36-2316 para 1.7.4.

2. Any duty away from home station will require a statement of the member's current medical status from her private physician. This statement must be submitted 30 days prior to departure to the medical unit and travel approved by a military physician.

3. After delivery, and when cleared by her obstetric care provider, the member must return to the medical unit for evaluation by a military physician and to be cleared for return to military duty.

4. Subject member is deferred from the fitness program for a period of 12 months after the date of discharge from the hospital after deliver.

5. Member will not participate in mask confidence training.

6. Wear of the CWDE will be dependent upon the ambient temperature until 20 weeks' gestation age or until the CWDE no longer fits.

a.If the ambient temperature is below 70 Fahrenheit, full participation is allowed.
b. If the temperature is greater than 70 degrees Fahrenheit, only mask, hood, and helmet are worn. The flak vest is not worn or carried.

7. After 20 weeks' gestation, the member will demonstrate proficiency in donning the mask at the commencement of an exercise or training. After completing the proficiency demonstration, the member will carry the mask but is not required to use it. The helmet, flak, vest, web belt, and chemical protective suit will not be carried or worn.

Note: *All participation (including beyond UTA/AT during pregnancy is governed by AFMAN 36-2136. Pregnancy is not considered to be a medical condition for the purpose of a LOD determination.*

Medical Interviewer Signature
Attachment AF Form 469

Attachment 18
BRIEFING STATEMENT

1. While pregnant, you may participate in a restricted status until your 34th week of pregnancy or you may volunteer to participate from the 34th week of pregnancy to term, provided you fall within the parameters of AFMAN 36-2136 para 1.7.4, and you, the unit commander/program manager, and obstetric care provider all support the decision for continued participation.

2. A military physician may restrict you from Reserve participation at any time the physician determines such action is appropriate.

3. You must bring in a letter from your obstetric care provider summarizing your current health, physical restrictions and expected date of delivery.

4. A periodic medical progress report from your private physician will be required every 60 days or more often if needed to determine continued fitness for military duties.

5. Military duty within CONUS performed away from home station must be cleared through this medical unit by a military physician.

6. For military duty away from home station, a statement from your private physician, accomplished within 30 days of departure, must be submitted through this medical unit to a military physician for approval of travel.

7. The letter from your private physician must include potential or actual medical complications, restrictions regarding physical activities, approval for travel, or any other facts deemed relevant to your care.

8. Should you go into labor while on IDT, you will be transferred to a civilian medical facility as soon as it is safe to do so, and you will incur any medical costs associated with delivery at the medical treatment facility. Pregnancy is not considered to be a medical condition for the purposes of a LOD determination.

9. After delivery and when cleared by your obstetric care provider you must come back to the medical squadron for evaluation by a military physician to be cleared for return to military duty.

Member's signature Date

Medical Interviewer Date

GLOSSARY

A1C – Glycosylated Hemoglobin *or* Glycated Hemoglobin
AAC - Assignment Availability Code
ACS - Aeromedical Consultation Service
ADLS - Advanced Distributed Learning Service
ADT - Active-Duty Training
AE - Aeromedical Evacuation
AED - Automatic External Defibrillator
AFRC - Air Force Reserve Command
AFSC - Air Force Specialty Code
AIB - Accident Investigation Board
AIMWTS - Aeromedical Management Waiver Tracking System
ALC - Assignment Limitation Code
AMP - Aerospace Medicine Program
ARB - Aeronautical Review Board
ARC - Air Reserve Component (AFR & ANG)
ART - Air Reserve Technician
ASF - Aeromedical Staging Facility
ASIMS - Aerospace Medicine Information Management System
AT - Annual Tour
ATLS - Advanced Trauma Life Support
BAMT - Blood Assay for M. tuberculosis
BE / BEE - Bio-Environmental Engineering
BLS - Basic Life Support
CBRNE - Chemical, Biological, Radiological, Nuclear, & Explosive
CCQAS - Centralized Credentials & Quality Assurance System
CCT - Cone Contrast Test
CDE - Commander Directed Mental Health Evaluation
CFR - Code of Federal Regulations
CME - Continuing Medical Education
COCOM - Combatant Commander
CPS - Clinical Preventive Services
CRM - Crew Resource Management
CXR - Chest X-Ray
AMRO - Deployment Availability Working Group
DLC - Duty Limiting Condition
DOEHRS-IH - Defense Occupational & Environmental Health Readiness System-Industrial Hygiene
DOEHRS-HC - Defense Occupational & Environmental Health Readiness System-Hearing Conservation
DR - Duty Restriction
DS - Duty Status
ECG - Electrocardiogram (see EKG)
ECT - Electronic Case Tracking system

EKG - Electrocardiogram (see ECG)
EMS - Emergency Medical Services
FA - Fitness Assessment
FAA - Federal Aviation Administration
FAE - Fitness Assessment Exemption(s)
FM - Flight Medicine
FOMC - Flight & Operational Medicine Clinic
FPEB - Formal Physical Evaluation Board
FR - Fitness Restriction(s)
FS - Flight Surgeon
GYN - Gynecology
HAZMAT - Hazardous Material(s)
HBV - Hepatitis B Virus
HIV - Human Immunodeficiency Virus
HRA - Health Risk Assessment
ICD - International Classification of Diseases (ICD)
IDS - Integrated Delivery System
IDT - Inactive Duty Training
IFC - Initial Flying Class
IMR - Individual Medical Readiness
IMA - Individual Mobilization Augmentee
IPEB - Informal Physical Evaluation Board
IR - Individual Reservist
IRILO - Initial Review In Lieu Of (Medical Evaluation Board)
IRR - Individual Ready Reserve
Kx - AFMS Knowledge Exchange
LOD - Line of Duty
LTBI - Latent Tuberculosis Infection
MAJCOM - Major Command
MARE - Major Accident Response Exercise
ME - Medical Evaluation
MEB - Medical Evaluation Board
MEHP - Medical Employee Health Program
MEPS - Military Entrance Processing Station
MFS - Medical Flight Screening
MISCAP - Mission Capability
MMHE - Military Mental Health Evaluation
MOA - Memorandum of Agreement
MOU - Memorandum of Understanding
MQT - Mission Qualification Training
MR - Mobility Restriction
MRDSS - Medical Readiness Decision Support System
MSD - Medical Standards Directory (supplement to DAFMAN 48-123)
MSE - Medical Surveillance Examination
MTF - Military Treatment Facility
MUQ - Member Utilization Questionnaire

NARSUM - Narrative Summary
NDDES - Non-Duty Disability Evaluation System
NIDDM - Non-Insulin Dependent Diabetes Mellitus
NOTAM - Notice to Airmen
NVG - Night Vision Goggles
OMS - Occupational Medical Service
OPRF - Operational Readiness Flight
ORM - Operational Risk Management
OSHA - Occupational Safety & Health Administration
PAP - Papanicolaou smear
PCE - Primary Care Element(s)
PEB - Physical Evaluation Board
PEPP - Physical Examination Processing Program
PH - Public Health
PHA - Periodic Health Assessments
PLHCP - Physician or Other Licensed Health Care Professional
POC - Point of Contact
PRP - Personnel Reliability Program
PULHES - Physical Condition Upper Extremities Lower Extremities Hearing (Ears) Vision (Eyes) Psychiatric Stability
R&D - Research & Development
RILO - Review In Lieu Of (Medical Evaluation Board)
RMU - Reserve Medical Unit
RFA – Returned for Action
RPP - Respiratory Protection Program
RSG - Regional Support Group
SABC - Self-Aid & Buddy Care
SAF - Secretary of the Air Force
SAMMC - San Antonio Military Medical Center
SAR - Search and Rescue
SCL - Soft Contact Lens
SCT – Sickle Cell Trait
SGH - Chief of Professional Staff
SGP - Chief of Aerospace Medicine
SIB - Safety Investigation Board
SME - Subject Matter Expert
Sr ART - Senior Air Reserve Technician
TB - Tuberculosis
TR - Traditional Reservist
TRAC2ES - Transportation Command Regulating & Command &Control Evacuation System
TST - Tuberculin Skin Test
UPT - Undergraduate Pilot Training
UTA - Unit Training Assembly
UTC - Unit Task Code