DEPARTMENT OF THE AIR FORCE
AIR FORCE RESERVE COMMAND

1 Jun 2015

MEMORANDUM FOR RESERVE MEDICAL UNITS

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

SUBJECT: Consolidated Program Memorandum 2015

1. This memorandum has been extensively edited, and should be reviewed in its entirety.

2. We continue to write and coordinate on policy with the goal of including ARC-specific issues to the fullest extent possible. Where we are unable to fully indicate reserve requirements for medical programs, this memorandum should provide additional guidance.

3. Recommended additions, corrections, or questions may be submitted to the AFRC/SGP organizational mailbox at afrc.sgp@us.af.mil or the AFRC/SGP discussion page on the AFMS Knowledge Exchange (Kx) at https://kx.afms.mil/kj/kx7/AFRCAerospaceMed.

//signed//

Brian Pinkston, COL, USAFR, MC, SFS
Chief, Aerospace Medicine & Professional Services Division
Directorate, Health Services
Air Force Reserve Command

HQ AFRC/SG

CONSOLIDATED PROGRAM MEMORANDUM (CPM)

1 JUN 2015

Reserve Medical Standards: This memorandum provides guidance and clarification for medical management of Reserve personnel by expanding upon other Instructions regarding specific Reserve medical and dental standards. This memorandum may be more restrictive than the existing AFI or other guidance in the governance of Reserve members. Consult DoDI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services* for medical standards for accession.

Contents

PART I - Operational Guidance 4
Section I: RMU Operations 4
Section II: Medications 10
Section III: ECT Guidance 11
PART II - Instruction Guidance 12
Section I: AFI 48-123 12
Section II: Medical Standards Directory (MSD) 15
Section III: AFI 10-203, Duty Limiting Conditions 19
Section IV: AFI 48-145, Occupational and Environmental Health Program 22
Section V: AFI 48-137, Respiratory Protection Program 22
ATTACHMENT 1 – Medical Disqualification for Military Duty Fact Sheet 25
ATTACHMENT 2 – Medical Evaluation (ME) for Military Duty Fact Sheet 26
ATTACHMENT 3 – Certification of Refusal to Sign 30
ATTACHMENT 4 – Request for Information Template 31
ATTACHMENT 5 – Member Utilization Questionnaire Template 32
ATTACHMENT 6 – IRILO Coversheet 34
ATTACHMENT 7 – HIV Initial Notification Memorandum Template 35
ATTACHMENT 8 – Commander Notification Memorandum Template 36
ATTACHMENT 9 – HIV Second Notification Memorandum Template 37
ATTACHMENT 10 – Flight Surgeon Skills Maintenance 38
ATTACHMENT 11 – AFRC Flight Surgeon 48X3 Mission Qualification Training (MQT) 41
ATTACHMENT 12 – AFRC Conventions for CCQAS 42
ATTACHMENT 13 – AF Form 469 Duty Limiting Condition (DLC) Report Flow Chart 43
ATTACHMENT 14 – Narrative Summary Medical Template 44
ATTACHMENT 15 – Narrative Summary Psych Template 47
GLOSSARY 49

PART I - Operational Guidance

Section I: RMU Operations

1. Purpose. During UTAs, the mission of our RMU is to train and provide physical exam/fitness for duty evaluations. Professional staff (i.e. physicians, physician assistants, nurse practitioners, nurses, dentists, optometrists, etc.) and medical technicians are not available during drill periods to provide routine medical/dental care. Unless a Reservist is on active duty, all non-emergency medical/dental care must be obtained from private health care providers. Emergent care is limited to Self-Aid and Buddy Care (SABC)/Basic Life Support (BLS) care until arrival of Emergency Medical Services (EMS).

2. Medical Standards Policy. Reserve Medical/Dental Care Policy.

2.1. 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 fortunate enough to have an ambulance included in their equipment inventory may only use it for training purposes.

2.2. Sick Call. Sick call is not provided by RMUs. Commanders are requested to notify the RMU when Emergency Medical Services (EMS) are utilized in order to facilitate proper documentation in the medical record. Airmen are required to report medical data to the RMU IAW AFI 48-123 paragraph 10.4.2.

2.2.1. Reservists determined unable to complete the UTA will be referred back to their commander (or Individual Augmentee Program Manager for IMA personnel) with recommendation from the Reserve physician that the member see his/her private healthcare providers. The service member is then expected to bring information back from the healthcare provider for the RMU to determine future fitness for duty.

2.2.2. An AF Form 469, *Duty Limiting Condition Report* (also known as a DLC or "profile"), need not be created for a time limited condition (IE viral illness, gastroenteritis, etc.) unless the medical/dental condition is considered disqualifying for retention as defined in the Medical Standards Directory (MSD) supplement to AFI 48-123.

2.3. Medication Stocks. RMUs are not authorized to stock medication except as required to support deployment processing, aviator ground testing, or the administration of immunizations.

3. Air Force Reserve Suicide Prevention - Procedures for Managing Suicidal and/or Homicidal Reserve Personnel.

3.1. 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. The evaluation must be conducted by a clinically privileged provider in accordance with current legal guidance and other standards of care. RMU's do not have privileged and credentialed military providers authorized to perform safety or diagnostic assessments. Potential suicide and/or homicide are situations that should be handled via local EMS resources.

3.2. 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 in accordance with current Air Force policy. 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.

3.3. Reservists that receive emergent referrals for suicidal, homicidal, destructive, or psychotic communications or actions will immediately be made Code 31 and shall not participate until completion of a Military Mental Health Evaluation (MMHE) with an appropriate recommendation for return to duty.

3.4. Suicide Attempts and Events.

3.4.1. Reporting: Suicide attempts and completed suicides will be reported and reviewed after the event IAW current DoD, AF, and HQ AFRC guidance [AFI 90-205, Suicide Prevention Program and/or DoD Suicide Event Report (DoDSER) found online at: http://dodser.t2.helath.mil or by searching for "DoDSER"].

3.4.2. Suicide Attempts.

3.4.2.1. All suicide attempts require a Fitness for Duty (FFD)/ World Wide Duty (WWD) or

Medical Evaluation Board (MEB) as applicable based on line of duty finding.

3.4.2.2. Airmen who attempt suicide are at high risk for a number of adverse outcomes. Their fitness for military duty must be carefully evaluated to ensure a successful mission and the safety of co-workers, family members, and the individual. This requires a comprehensive mental health evaluation by an Active Duty Mental Health Provider and must address all items outline in Attachment 15 of this document.

3.4.2.3. MEB will be accomplished for suicide attempts found in the Line of Duty. Airman who 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.)

3.4.2.4. FFE/WWD Evaluation will be accomplished for suicide attempts found not to be in the Line of Duty. Airmen who attempt suicide while not in a military status will require assessment of their continued qualification for military duty as noted in paragraph 11.16.2.1 below. 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 LOD determination. If there is no service connection, the RMU will process a medical evaluation per this policy.

3.5. Completed suicides. All events will be reviewed and reported of this document. Direct all questions to HQ AFRC/SGP, Command Mental Health Officer or encrypted via afrc.sgp@us.af.mil.

3.6. Documenting Suicide Prevention Training: All suicide prevention training will be recorded in the Advanced Distributed Learning Service (ADLS). AFRC airmen who complete the training using the ADLS or other computer-based method, will automatically have their training record updated. FI the "in-person" training method is used, Commanders are responsible for ensuring that unit training managers, or their designee, manually document the training in ADLS to ensure individuals receive full credit.

3.7. Reporting Suicide Prevention Training: HQ AFRC/SG is the Subject Matter Expert (SME) for the ARFC Suicide Prevention Program (AFRSPP) and the HQ AFRC Integrated Delivery System (IDS) chair is the OPRF for collecting training reports. Semi-annually, the wing IDS chair will forward training reports to the HQ AFRC IDS chair. The HQ AFRC IDS chair will then report the wing's training status as requested or required.

4. Credentials.

4.1. Within the RMU, providers are only privileged to provide physical exam support. Privileging for professional staff at collocated RMUs may include providing medical treatment in AD medical facilities and clinics. Such treatment would only be provided to eligible beneficiaries.

4.1.1. 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, AT, etc.) at their home duty station. Only basic life support augmented with Automatic External Defibrillating is authorized.

4.1.2. 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 A Physician's Master Privilege List as used in CCQAS.

4.2. Credentialing and Privileging Issues.

4.2.1. IAW AFI 44-119, Medical Quality Operations, Reserve providers in a deployable Unit Task Code (UTC) are required to maintain 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 MISCAP). All Reserve providers need to maintain a UTA privilege list as defined on a Physician's Master Privilege List as used in CCQAS.

4.2.2. The management of the credentialing and privileging process must be under the professional oversight of the senior physician (SGH/Chief of Professional Staff) in the RMU. This senior physician is, in turn, privileged by the active duty MTF/CC if co-located or by the AFRC/SGP if the RMU is not co-located with an active duty MTF.

4.2.3. All providers are responsible for reviewing and understanding the application of UTA privileges. Practice outside UTA scope can result in loss of privileges.

5. Extension of Military Orders for Reservists with Medical Conditions.

5.1. RMU responsibility: To advise the immediate Commander of the member's current medical status, current AF Form 469, *Duty Limiting Condition Report*, and whether the member may safely perform military duty. The RMU does not advise on whether a member can return to civilian employment. The RMU is also required to initiate LODs for potentially service connected injuries or illness IAW AFI 36-2910.

5.2. RMU's are not responsible for approving or disapproving extension of military orders IAW AFI 36-2254 Vol I para 1.6.5.2. 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.

6. Expired PHAs or other medical/dental requirements. If a member has not completed a PHA or other medical/dental requirements before the expiration of the current periodic exam or other IMR medical/dental requirement, you may create an AF Form 469 with AAC 31 using diagnosis code V70.3 and route appropriately. Document the member's non-compliance, delinquency of medical/dental requirement and if you use the AF Form 469, document the member's restriction from Reserve participation for pay and points IAW AFI 360-2254 V1. If it is used, once signed and completed, the AF Form 469 will automatically notify the unit commander via ASIMS.

7. Medical Evaluations to Determine Fitness for Duty (FFD).

7.1. Processing Medical Evaluations for Medically Disqualifying, Non-duty Related Medical/Dental Conditions.

7.1.1. This process only applies to Reservists identified with medically disqualifying non-duty related medical or dental conditions IAW MSD retention standards. Non-duty related is defined as not having occurred or been aggravated by military duty. RMU commanders must ensure appropriate personnel are thoroughly familiar with the contents of this section. RMU personnel should also review and become familiar with the memorandum HQ AFRC/DPM on the Management of Reservists with Non-Duty Related Medically Disqualifying Conditions.

7.1.2. RMU responsibilities when evaluating Reservists with medically disqualifying non-duty related medical conditions. These responsibilities will be accomplished when the Reservist is placed on the DLC.

7.2. Counseling Reservists with Non-Duty Related Disqualifying Medical/Dental Conditions.

7.2.1. Counsel the member on all medical aspects of the process. Advise the member that he/she will be given 60 days to provide medication documentation from civilian and/or military medical sources to support their case. AFI 10-203 describes the commander's role in ensuring compliance of medical documentation.

7.2.2. Counsel the member that the standards in the MSD are used to determine the medical qualification for continued military duty. Any condition unacceptable for continued military duty is reason for AFRC/SG to perform FFD/WWD medical evaluation.

7.2.3. Ensure the member understands that HQ AFRC/SG 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, the Secretary of the Air Force (SAF) will be the military authority who determines the member's fitness for continued military duty.

7.2.4. Advise the member that their medical evaluation will be submitted to HQ AFRC/SGP with or without the member's input at the end of the allotted time

7.2.5. Advise the member that "Failure to complete, sign, date, and return the PEB Election form to (name RMU) in the allotted time constitutes a waiver of your right to have your case reviewed by the PEB for fitness for duty." Thereby making HQ AFRC/SG the final military authority determining fitness for duty.

7.2.6. Advise the member of the point of contact (POC) and his/her contact information for the case.

7.3. Notification.

7.3.1. Review the following documents detailed below in 13.4. with the member. Provide copies after member has signed all documents.

7.3.2. Request for information letter. This letter should match the briefing described in 13.2.

7.4. Medical Evaluation (ME) for Military Duty Fact Sheet (Attachment 2). Note: If the member wishes to waive the "60-day" period or has no additional medical information to provide, ensure the member

reads, signs, and dates the following statement on the ME Fact Sheet: “I have nothing further to submit for consideration and waive the minimum 60-day period. I want my case processed as soon as possible.”

7.4.1. PEB Fact Sheet (Attachment 2a).

7.4.2. PEB Election Form (Attachment 2b).

7.4.3. AF Form 469 (Member Copy).

7.4.4. Unit Commander’s Memorandum (Attachment 2c). Forward to the member’s commander, the Unit Commander Memorandum with AF Form 469 (unit commander copy) attached.

7.4.5. The RMU will advise the unit commander on all medical aspects of the member’s case. The case will be submitted to HQ AFSC/SGP through the Electronic Case Tracking (ECT) system.

7.4.6. 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 Assignment Limitation Code (ALC) action or “unfit” finding by Informal PEB/ Formal PEB when PEB is requested by member.

7.4.7. When the member is not presently on a deployment limiting code the RMU will take the following action:

7.4.7.1. Send a Request for Information memorandum (Attachment 4) to the member via certified mail with return receipt and address correction requested. The memorandum will explain the medical action taken by the RMU and include the name and phone number of the RMU POC. It will also advise the member that he/she has 60 days from the date of the memorandum to provide the RMU with the signed and dated ME fact sheet, signed and dated PEB Election Form, and any supporting medical documentation from civilian or military medical sources. The following statement will also be included:

7.4.8. “If the requested information is not received by {name of RMU} within the allotted time, your case will be submitted to HQ AFRC/SGP for review and appropriate action. Failure to complete, sign, date, and return to the PEB Election Form to {name of RMU} in the allotted time constitutes a waiver of your right to have your case reviewed by the PEB.”

7.5. The following documents must be included as attachments to the member’s memorandum:

7.5.1. AF Form 469 (member copy).

7.5.2. Unit Commander Memorandum (copy, Attachment 2c).

7.5.3. ME Fact Sheet (original and copy for member, Attachment 2).

7.5.4. PEB Fact Sheet (Attachment 2a.).

7.5.5. PEB Election Form (original and copy for member, Attachment 2b).

7.6. Postal Service Actions.

7.6.1. 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.

7.6.2. If the postal service returns the mail as undeliverable (i.e. address is correct but member refused receipt), then 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 forward the member’s case to HQ AFRC/SGP for review and appropriate action.

7.6.3. The RMU will include in the cover memorandum to HQ AFRC/SGP a detailed explanation of all attempts made to contact the member. Also included in the package will be a copy of the memorandum sent to the member and the original and appropriate number copies of the Postal Service Form 3811 from the US Postal Service.

7.7. Member Utilization Questionnaire: The MPF will provide the RMU with the “Member Utilization Questionnaire” (MUQ, Attachment 5) completed by the member’s unit commander and endorsed by the wing or Regional Support Group (RSG) commander. The MUQ will be returned to the RMU within 60 days from the date the MPF was notified of the medical action. The RMU will not submit the member’s case without the MUQ if the 60-day suspense has not lapsed, even if the member indicates he/she has nothing further to add to the FFD/WWD case.

7.7.1. If after the 60-day suspense, the MPF has not provided the RMU with the MUQ, the RMU will forward the member’s case to HQ AFRC/SGP without it.

7.7.2. The cover letter from the RMU will reflect the date the MUQ was requested and that the MPF did not provide it prior to submission of the case.

7.8. 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/SGP. A case submitted earlier than them minimum 60-day period must include the MUQ and statement from the member (signed and dated) indicating he/she has waived the minimum 60-day period.
7.9. The RMU will initiate an AF Form 469 to remove the deployment limiting code. Notify the member, member's commander and the MPF of the member's return to duty if found medically qualified by HQ AFRC/SG or fit for military duty by Informal PEB / Formal PEB / SAF.
7.10. Accompanying Documents. The following documents are included in the reports forwarded to HQ AFRC/SGP for review via the ECT system.
7.10.1. For unit-assigned or IMA Reserve members:
7.10.1.1. Civilian and military medical and dental documentation relevant to the submission.
7.10.1.2. Current letter from the member's private medical provider or dentist.
7.10.1.3. AF Form 469.
7.10.1.4. Narrative Summary.
7.10.1.4.1. See Attachment 14 for general narrative summaries
7.10.1.4.2. See Attachment 15 for mental health summaries.
7.10.1.4.3. Instructions to the military provider preparing the 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 make a decision. 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. Include pertinent documentation but don't make the reviewer dig through huge volumes of paperwork to find supporting documentation or to answer a question. 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.). Be sure to address all disqualifying conditions and potentially disqualifying conditions (those listed in the MSD but meet retention standards) in the summary. Base your conclusions and recommendations 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. 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. Please address the issue specifically in the NARSUM. Formal AF348 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. Rest assured that any decision affecting an individual's career is taken very seriously and is made with careful review. 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.
7.10.1.5. ME for Military Duty Fact Sheet (Attachment 2).
7.10.1.6. PEB Fact Sheet (Attachment 2a).
7.10.1.7. PEB Election (Attachment 2b).
7.10.1.8. Unit Commander's Memorandum (Attachment 2c).
7.10.1.9. Member Utilization Questionnaire from local MPF (Attachment 5).
7.10.1.10. IRILO Coversheet (Attachment 6).
7.10.1.11. Copy of member memorandum (Attachment 1) and Postal Service Form 3811 (original and appropriate copies) when member was not present at the time of the MR DLC action and notification was made by mail.
8. Commander Directed Mental Health Evaluations
8.1. Commander Directed Mental Health Evaluations (CDE) must be conducted IAW AFI 44-109,

Mental Health and Military Law. The procedures for this evaluation process are intended to protect the rights of the individual (REF: Public Laws 101-510 and 102-484 and DODD 6490.1, Mental Health Evaluations of Members of the Armed Forces and DoDI 6490.4, Requirements for Mental Health Evaluations of Members of the Armed Forces), 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.

8.2. HQ AFRC/SGP may require a MMHE as part of an occupational or worldwide duty/deployment evaluation. This is not the same as a CDE. The sole purpose of this evaluation is to determine if the member meets eligibility for continued military service. If the member does not consent the consequences are limited to grounding or placement in a "no pay no points" status for non-compliance.

9. Failure to Show for Medical/Dental Appointments

9.1. AFRC members who fail to show for medical/dental appointments are referred to their commanders for processing IAW AFI 26-3209. A member 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. Refusal to cooperate with medical requests prompts the following actions detailed below.

9.2. Procedures less than 6 months overdue. RMU's may take the following actions when a member fails to appear for a scheduled medical/dental appointment if requirement is less than 6 months overdue:

9.2.1. Generate AF Form 469 with code V70.3.

9.2.2. Document member's failure to appear and date member's commander was notified on SF 600 or equivalent electronic method to be included in member's official military medical record.

9.2.3. Track the case through DAWG via IMR stats.

9.3. Procedures more than 6 months overdue. RMU's shall take the following actions when a member fails to appear for a scheduled medical/dental appointment if the requirement is over 6 months overdue:

9.3.1. Generate AF Form 469 with code V70.3.

9.3.2. Document member's failure to appear and date member's commander was notified on SF 600 or equivalent electronic method to be included in member's official military medical record.

9.3.3. Track the case through DAWG via IMR stats.

10. Failure to Comply

10.1. Refusal to provide requested information for FFD/WWD regarding known permanent medical/dental conditions within 60 days:

10.1.1. The RMU will annotate on SF 600 or equivalent electronic method the time afforded an individual member for the provision of requested evaluations and/or additional information. These cases will be tracked by the DAWG.

10.1.2. With continued refusal to comply, RMUs will prepare a worldwide duty package consisting of all available information and a NARSUM which includes details on the member's refusal. The package will then be submitted to HQ AFRC/SGP for appropriate action. The case should be processed by the unit commander for administrative action. Medical case processing is never a substitute for proper administrative disposition. Failure to comply is a commander's process as is outlined in AFI 10-203.

10.1.3. Known temporary medical/dental conditions. Members who refuse required medical, surgical, or dental treatment or diagnostic procedures for a NON-PERMANENT condition (for example dental carries or hernia that requires repair) will be placed on failure to comply status.

10.1.3.1. The member is referred to his or her unit commander to managed IAW AFI 10-2903, AFI 36-3206 paragraph 2.2.6., AFI 36-3208 and/or AFI 36-3209 as appropriate. Failure to obtain treatment to remedy such temporary conditions may render an individual unsuitable (as opposed to unfit) for continued military service and subject to administrative action by their commander.

10.1.4. Pregnancy. If a female fails to return to her servicing RMU for follow-up six weeks following expected date of delivery the following procedures will be followed:

10.1.4.1. The member will contact the RMU if she has complications with her pregnancy in accordance with AFI 48-123 paragraph 10.4.2.

10.1.4.2. If the member did not have complications and she or her commander fails to contact the RMU NLT 6 weeks postpartum, the RMU will remove the Code"81" and process as an expired medical requirement IAW AFI36-2254 Vol I and generate non-compliance AF Form 469.

11. Use of DD Form 2766 Adult Preventive and Chronic Care Flow Sheet

11.1. All medical records will have a DD Form 2766 on file and must accompany the Reserve member when they deploy OCONUS for 30 days or more.
11.2. The current DD Form 2766 will be copied prior to deployment and filed in the medical record with original accompanying the individual to deployed location. If the deployed member receives medical care, all documentation will be placed with the DD 2766 for return with member upon re-deployment. Upon return place medical documentation in the consolidated medical record.
11.3. Complete 5 and 7 of DD Form 2766
11.3.1. PHS 731, International Certificates of Vaccination, Yellow Fever Shot Record is only required for specific deployment locations
11.3.2. All immunizations must be entered into ASIMS as appropriate.
11.3.3. Document the date the PHA and ASIMS data entry is completed in Section 10 “Readiness” just under “Fitness”
11.3.4. For flyers, document all required ground testing of all operational medications with the date and approved or disapproved in Section 3 under medications. For additional guidance on operational ground testing see Section II of this guidance.

Section II: Medications

1. Fatigue Countermeasures Program. 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 AFI 11-203V3, *General Flight Rules*, Chapter 9 Crew Rest, Fatigue Management and Flight Duty Limitations and in AFI 48-149, *Flight and Operational Medicine Program*, Chapter 7 Fatigue Countermeasures Program. The Command supports dispensing of counter-fatigue medication by a Reserve medical unit for the purposes of ground testing medications, under carefully controlled circumstances. There are no 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.
1.1. Policy - Policies and forms for operational ground testing will generally be maintained at the AFMS Knowledge Exchange (Kx) website at https://kx2.afms.mil/kj/kx4/FlightMedicine/Pages/operationalmedhomeapril2012.aspx. Additional sources for operational ground testing information are found in links embedded in the Aircrew Medical List. Finally, reference MAJCOM specific restrictions and policy guidance which can generally be found on the Kx or published to the MAJCOM website.
1.2. Education - Pharmaceuticals should only be used as part of a comprehensive counter-fatigue program. Fatigue avoidance tools and other resources to combat fatigue are available and should be familiar to the unit level Flight Surgeon and/or unit SGP. Flight Surgeon Tools include predictive tools and apps which have published to include such as FAST, FlyAwake, or CrewAlert. These are important adjuncts to the flight surgeon tasked with joint authority for approval of medication use on selected high risk missions.
1.3. Ground testing - Ground testing is essential to ensure operational use. 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.
1.4. Approval for Medication Use.
1.4.1. 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.
1.4.2. 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 SGP to ensure other risk mitigation strategies have been considered and implemented.
1.5. Medication Handling - Each RMU must have a written plan that addresses the security, storage, and distribution of controlled substances IAW AFI 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.

1.5.1. Medications may only be dispensed by a Reserve Flight Surgeon is on active status. All appropriate documentation must be completed concomitantly with dispensing.

1.5.2. Bases with Collocated Active Duty MTF. 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.

1.5.3. For non-Collocated Bases:

1.5.3.1. If appropriate storage facilities are available, obtain medications for the purpose of ground testing and issuance IAW AFI 41-209. This medication should be obtained through logistics supply form the supporting MTF.

1.5.3.2. 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.

1.5.4. Unused Medication. All unused pills must be returned and that return and their destruction documented IAW with all applicable policies and procedures.

1.5.5. Non-deployed Environment. Use medications for only approved mission sets. Routine home station use is not approved.

1.6. HQ AFRC/SGP Oversight. HQ AFRC/SGP will through the appropriate chain of command 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.

1.7. HQ AFRC/SGP 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. HQ AFRC/SGP will be glad to assist any unit with an operational mission need to establish a functional program.

2. 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.

2.1. Ground Testing. 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.

2.2. Ciprofloxacin for ground testing should 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.

2.3. 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.

Section III: ECT Guidance

1. Purpose. The Electronic Case Tracking system is integral to the efficient and timely adjudication of a variety of cases submitted for HQ AFRC/SG review and action. The following is provided for informational purposes to help the RMU enter the case into the correct queue and avoid delays.

2. Case Types in ECT.

2.1. Deployment Waiver. These cases will be used for those member who require a waiver to deploy. This includes those on an assignment limitation code (C1/C2/C3) and those who need approval by COCOM specific reporting instructions. Generally these will have CED orders for a named

operation/deployment. AFRC/SG reviews 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.
2.2. Modification. These cases will be for those members on an assignment limitation code 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.
2.3. Participation Waivers. These are for those members who are on Code 31 or Code 37 restrictions as found on AF Form 469. This will allow a member deemed by HQ AFRC/SGP to be low risk and safe with a disqualifying condition to participate at home station for UTA or Annual Tour only. It does not allow for off station participation except for medical evaluation as required as part of a FFD/WWD or MEB evaluation. Reference Part II Section III 1.3.5 of this guidance for further information. Once a FFD/WWD determination has been made by AFRC/SGP, a participation waiver is no longer valid as the determination supercedes the temporary waiver.
2.4. RILO. These cases are the initial review by HQ AFRC/SGP for FFD/WWD or MEB packages. It allows for expeditious return of service members who do not need full case adjudication. It is the initial look by HQ AFRC/SGP and will be returned for either full case processing, returned without restrictions, or returned with restrictions (i.e. ALC Coded).
2.5. FFD/WWD. These cases are for non-duty related disqualifying conditions after initial RILO. This will included those cases adjudicated as return to duty and need periodic review by HQ AFRC/SGP.
2.6. MEB. These cases are for duty related disqualifying conditions after initial RILO. This includes those cases which have been adjudicated and are being periodically reviewed for continued ALC C status or disqualification.

PART II - Instruction Guidance

Section I: AFI 48-123
CHAPTER 1 – GENERAL INFORMATION AND ADMINSTRATION PROCEDURES
Section 1B – Medical Examinations

1.2. Medical Examinations.
1.2.1. For AFRC/SGP certification consideration of Commissioning applicants, the RMU must also provide a completed DD 2807-2 with the most recent PHA and AF 422. Alternatively the RMU may accomplish a PEPP package (DD 2808/2807-1).
1.2.3. Locations.
1.2.3.2. Military Entrance Processing Station (MEPS).
1.2.3.2.1. MEPS Disqualification. Reserve Medical Units (RMUs) cannot override a previous MEPS disqualification. Individuals who wish to present additional medical information on their behalf must be referred back to the MEPS. No profile or disqualification done at MEPS will be changed, except as follows:
1.2.3.2.1.1. An H-2 (hearing) profile given by MEPS may be adjusted to reflect the correct Air Force hearing standard IAW MSD. Annotate the correct profile on back of the DD Form 2808, *Report of Medical Examination*, with a remark that the hearing profile was adjusted to Air Force standards. An H-3 profile given by MEPS may not be adjusted. Repeating the audiogram is not required to adjust the hearing profile in these cases, but may be accomplished by the RMU at the discretion of the Hearing Conservation Program manager.
1.2.3.2.1.2. An E-3 (eyes) profile granted by MEPS cannot be adjusted and is considered disqualifying for enlistment except for those prior service applicants processed under retention standards according to AFI 48-123.
1.2.3.2.1.3. HQ AFRC/SG, MEPS and RMUs are authorized to change profiles on individuals who have exceeded body fat standards, but have since come within standards.
1.2.4. Required Baseline Tests
1.2.4.2. G6PD Deficiency. 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 G6PD deficiency". "This may affect OCONUS duty if terminal malaria prophylaxis (i.e., primaquine) is warrant. The member's Unit Commander, Wing Flight Surgeon and CINC should be involved in any deployment decision where malaria prophylaxis is specifically required.

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

1.2.4.2.8. Pelvic exam, breast examination, papanicolaou smear, and mammogram (age 40 or older) are required on all initial flying, commissioning, and enlistment physical examinations accomplished on female applicants.

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

1.4. Physical Examination Quality Control

1.4.1. Resources. There are several resources that should be used to improve the quality of the Periodic Health Assessments (PHA):

1.4.1.1. AFI 48-123, *Medical Examination and Standards*

1.4.1.2. The Medical Standards Directory (MSD)

1.4.1.3. Physical Examination Techniques Directory is located on the AFMS Kx https://kx.afms.mil/flightmedicine and specifically https://kx.afms.mil/kj/kx4/FlightMedicine/Pages/physical_examination_techniques_directory-oct_2012.aspx (not working)

1.4.1.4. AFI 10-203 describes procedures for duty limitation.

1.4.1.5. AFI 44-170, *Periodic Health Assessment (2014)*

1.4.1.6. AFRC Preventative Health Assessment User Guide.

1.7. For time sensitive, SORTS reportable, mission essential recruiting efforts, consideration should be given to establishing a liaison (i.e. MOU/MOA) with a nearby active duty to see if, on a case-by-case basis, you could enlist their support in quick-turning a physical. This could solve the problem with flight surgeon availability between UTAs.

1.8. DoDI 6130.03. Local accession physical examinations must meet DoDI 6130.03 standards. Any deviation from these DoDI standards requires a waiver from AFRC/SG.

1.9. Physical Examination Processing Program (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/waiver authorities in programs such as Aeromedical Management Waiver Tracking System (AIMWTS), and PEPP. All have attachment capabilities.

1.9.1. 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.afms.mil/pepp/pmhe.

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

1.10. Initial Flying 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 IFCII Flight Surgeon (FS) exams will be conducted at Wright-Patterson AFB similar to the IFCI exam process. Applicant(s) should contact the local Reserve Medical Unit (RMU) for questions. Instructions for obtaining these examinations can be found at http://www.wpafb.af.mil/library/factsheets/factsheet.asp?id=20352.

1.10.1. The member must review the "FCI Pre-Screen" directions at http://www.wpafb.af.mil/library/factsheets/factsheet.asp?id=20363 and submit a completed "Personal Data Form" to the RMU or Recruiter.

1.10.2. The RMU or Recruiter will review the form for completeness, then attach the other required documents as follows:

1.10.2.1. 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.
1.10.2.2. 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.
1.10.2.3. Females ONLY: A GYN exam with PAP results within the last 10 months. The PAP results must be within 12 months of MFS exam date.

1.10.3. These documents are submitted to HQ AFRC/SGP (afrc.sgp@us.af.mil) for review and appointment scheduling at MFS. The RMU or Recruiter shall not circumvent HQ AFRC/SGP and contact MFS directly. Document processing includes the following:

1.10.4. 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"

1.10.5. The RMU or Recruiter should provide HQ AFRC/SGP the desired dates for scheduling. Not that MFS requires at least a minimum of 30 days advance notice for scheduling and 45 days advanced notice is customary.

1.10.6. HQ AFRC/SGP will notify the RMU or Recruiter of any required corrections, and notify of dates the member is scheduled.

1.10.7. 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.

CHAPTER 2 – RESPONSIBILITIES

Section 2A – Responsibilities

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

2.7.8. Clinical Preventive Services (CPS) ARE NOT offered to Reservists.

2.7.8.1. Skin exams previously required were intended to evaluate for scars/marks and are no longer required as this exam has evolved to CPS for skin malignancies. Skin changes such as surgical scars should be inquired about and appropriately documented as part of the medical history. Skin exam is no longer a requirement.

CHAPTER 3 – TERM OF VALDITY OF MEDICAL EXAMINATIONS

Section 3A – Term of Validity

3.1. Administrative Validity

3.1.3. Flying Training

3.1.3.5. All flight surgeon candidates for Aerospace Medicine Program (AMP) must possess a valid and current IFC II physical, regardless of the increment. This initial Flying Class II exam is valid for 48 months.

CHAPTER 6 – FLYING AND SPECIAL OPERATIONAL DUTY

Section 6A – Flying and Special Operational Duty Examinations

6.1. Flying and Special Operational Duty Examination

6.1.2. Medical examinations are required when:

6.1.2.6. IAW AFI 11-402 para.s 3.10.2. and 5.10.1., aircrew disqualified for at least one year and no more than five years will require HQ AFRC/A3 requalification. This requalification includes HQ AFRC/SGP medical recertification, which 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 FCII standard for Pilot/CSO/WSO personnel. Once AFRC/SGP certifies the PEPP package, the RMU then creates the AF 1042/DD 2992 in ASIMS.

6.1.2.7. Certification by HQ AFRC/SGP is required on physical exams accomplished for Aeronautical Review Boards (ARB). If the break is less than 12 months, the local fight surgeon clears the member for flying duty. If the break in service is greater than 12 months, submit a DD Form 2808/2807-1 (FC-II) via PEPP to the gaining MAJCOM/SG for review and certification. Submit flying waiver requests via the Aeromedical Management Waiver Tracking System (AIMWTS).

6.1.3. Medical Evaluation Scope.

6.1.3.1.4. At any point when examining Reserve flight surgeon learns of a 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 disqualify member/applicant locally.

6.1.5. Federal Aviation Administration (FAA) examinations will not be accomplished by Reserve physicians in military status.

6.1.6. FAA examinations will not be accepted in lieu of PHA requirements.

Section 6F – USAF Aircrew Corrective Lenses

6.20. Authorized Spectacle Frames for USAF Aircrew

6.20.1.4. Those units that are not supported by active duty equipment availability (non-collocated bases) should have received fitting sets for the new spectacles. The POC for fitting sets and the improved aircrew spectacle is NOSTRA email: NOSTRA-CustomerService@med.navy.mil or DSN 953-7600 or 757-887-7600 Option #1.

Section II: Medical Standards Directory (MSD)

Section A. Systemic and Other Diseases.

AFI 44-178*, Human Immunodeficiency Virus Program*

Chapter 2 - HIV PROGRAM

2.2. Populations Tested.

2.2.3. Human Immunodeficiency Virus (HIV) seropositivity, 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, para A4.3, confirm repeat positive enzyme immunoassay by Western Blot.

2.2.3.1. A positive HIV test result by itself is not medically disqualifying until confirmation of results is complete. Once a member is verified to have HIV seropositivity they are disqualified and placed on a code 37 utilizing AF Form 469.

2.2.3.2. Reserve members testing positive for the HIV antibody must have a FFD/WWD evaluation only if their immediate commander determines they may be utilized in the selected Reserve. The evaluation will follow the San Antonio Military Medical Center (SAMMC) Standard Clinical Protocol listed in AFI 44-178, Attachment 8.

2.2.3.2.1. The evaluation is at the **member's own expense** and 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.

2.2.3.3. The evaluation will be forwarded to HQ AFRC/SGP for review and appropriate action.

2.2.3.4. Reserve members who test positive for the HIV antibody and have been returned to duty by HQ AFRC/SG will be evaluated annually and their case forwarded to HQ AFRC/SGP 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.

Attachment 3 - AIR FORCE HIV TESTING PROCEDURES

A3.8.2.1 The AFRC Specific Guidelines for the HIV Program provide supplemental guidance to AFI 44-178, HIV Program, enabling management of Air Force Reserve (AFR) personnel infected with HIV. Adequate management of infected AFR personnel require the Competent Medical Authority to read, understand, and apply AFI 44-178 in combination with the guidelines.

A3.8.2.2. Reserve Medical Unit Commander (RMU/CC) is responsible for the HIV testing program and appoints an HIV designated physician and one or more alternates if desired.

A3.8.2.3. AFR personnel are screened for serological evidence of HIV infection every two years, preferably during their Preventive Health Assessment.

A3.8.2.4. 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.

A3.8.2.5. 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.

A3.8.2.6. Upon receiving the HIV positive test results, the RMU Sr ART will immediately notify RMU/CC.

A3.8.2.7. The RMU/CC reviews the reports and immediately notifies the wing/unit commanders of the positive HIV test results.

A3.8.2.8. The RMU Sr ART or RMU/CC will either notify the RMU's HIV designated provider, a physician at HQ AFRC/SGP, 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 advise 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. Individuals will be:

A3.8.2.12.1. Advised to 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. Women shall be advised of the risk of perinatal transmission during past, current, and future pregnancies. 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.

A3.8.2.12.2. Directed to immediately notify their spouse, if applicable, of their positive HIV status and have the spouse contact the notifying physician directly.

A3.8.2.12.3. Informed that their local Civilian Public Health (PH) Authority, in accordance with 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. The individual will provide a telephone number where they can be reached and will remain accessible for further communication.

A3.8.2.12.4. 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 in accordance with DoDI 1332.38. 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 8 to AFI 44-178.

A3.8.2.9. 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 Attachment 7 to AFI 44-178. The order is Attachment 13 to AFI 44-178. When the order is given, a credentialed provider must be present to answer any medical concerns of the member.

A3.8.2.10. If the member has a spouse, the designated physician will offer voluntary preventive medicine counseling and serologic testing to the spouse in accordance with AFI 41-210, TRICARE Operations and Patient Administration Functions, paragraph 2.17.

A3.8.2.11. 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.

A3.8.2.12. 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:

A3.8.2.12.1. V72.60 – Negative results

A3.8.2.12.2. V72.62 – Positive results

Section G. Chest Wall and Pulmonology (G8 – G12)

Tuberculosis Detection and Control Program

1. Program will follow AFI 48-105 *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*, Attch 3; AFI 44-108, *Infection Prevention and Control Program*; and the CDC *Core Curriculum on Tuberculosis*, 5th edition or most recent publication.

2. All HCWs will have a baseline TST or blood assay for *M. tuberculosis (BAMT)* documented in ASIMS Web using the MEHP module. Periodicity of future HCW testing will be based on the unit's TB risk assessment. If not already accomplished, a two-step TST will be performed per AFI 44-108 and CDC Core Curriculum. All deployers will have a baseline TST or BAMT documented in ASIMS prior to deployment. The baseline test may have been accomplished during Basic Military Training or Commissioned Officer Training. Testing upon redeployment will be determined based on member response to risk-based questionnaire. If post deployment testing is required, accomplish 90-120 days after redeployment per AFI 48-105, Attachment 3.

3. When a TST is administered, the results must be read 48-72 hours after administration. A qualified medical person (i.e. civilian public health authority, private or company physician, emergency room staff, school nurse, etc) may read and document the results. Unit member must bring proof of results to the medical unit during the next month's UTA. The result of the test is based on the presence or absence of an induration at the injection site. Redness or erythema should not be measured. The transverse diameter of induration should be recorded in millimeters. Self-reading of TST is not allowed. Criteria for determining TST positivity is outlined in CDC Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection, MMWR June 2000; 49 (No. RR-6) or most recent guidance.

3.1. Latent Tuberculosis Infection (LTBI) procedures

3.1.1. Member is given a AAC 31 on an AF Form 469 (perform duty at home station only).

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

3.1.2.1. If it is determined that a member has been deployed to a high risk area:

3.1.2.2. LOD initiated and member sent to active duty treatment facility.

3.1.2.3. If member is under treatment and TB is inactive, continue code 31 restricted to CONUS for the first month of treatment. After the first month, the member is returned to duty without restrictions, though a permanent change to a P2 in the PULHES should be documented on the AF Form 422.

3.1.2.4. If no treatment is necessary, no DLC action required.

3.1.2.5. If TB is in active stage, member is placed on a code 37 on the AF From 469 until completion of treatment and WWD/MEB processing.

3.2. If member has not been deployed - send to private physician. When member brings follow-up results from private physician:

3.2.1. If member does not have active TB but is under treatment, member requires an AAC 31 AF 469 and restricted to CONUS for one month, then returned to duty with permanent P2 profile update documented on the AF Form 422.

3.2.2. If physician determines member does not need treatment, no DLC action is required.

3.2.3. If member has active TB, code 37 until treatment is completed and member is determined to be inactive and processed through the WWD/MEB process.

Section H. Heart and Vascular (H1-H7, H54-H57):

1. Members who receive intracoronary stents with or without MI will have a FFD/WWD

evaluation to include a Radionucleotide Stress Test, if not contraindicated.
2. Coronary bypass surgery and coronary angioplasty procedures. The following documentation will be reviewed by the military physician accomplishing the evaluation. The military physician's assessment of the documentation will be included in the narrative summary. This documentation will also be included in the FFD/WWD package forwarded to HQ AFRC/SGP.
3. Narrative summary of hospitalization and current letter from the member's cardiologist stating interim medical history after surgical procedure, to include current medications and estimated length of time the medications will be necessary, functional impairment, restrictions of activity, and outline of planned medical follow-up. The cardiologist must also comment on any evidence of heart failure or myocardial ischemia.
4. Current exercise radionucleotide stress test or similar cardiac imaging study, if not contraindicated.
5. Admission/discharge reports, pre/post-op reports.
6. Members who must use any type of nitroglycerin for the treatment or prevention of angina are not considered medically qualified for military duty.

Section M: Endocrinology and Metabolic (M6):
Diabetes Mellitus

1. A diagnosis of "diabetes" will require that the member be placed on a "Code 37" and a medical evaluation case be forwarded for review by HQ AFRC/SGP (regardless of treatment). Well- controlled Non-Insulin Dependent Diabetes (NIDDM) is amenable to processing with a simple initial Review in Lieu Of case (IRILO).

1.1. Insulin Dependent Diabetes is medically disqualifying for worldwide duty.

1.2. NIDDM controlled with diet, exercise, or oral hypoglycemic or any combination of the three will require the following:

1.2.1. A complete statement from the member's private physician which must include medical history, diagnosis, and treatment, including results of previously established and current 2-hour post prandial glucose levels (for initial diagnosis only) and glycosylated (A_1C) hemoglobin levels (for initial and all renewals); comments on member's weight and diet regimen, and associated cardiac risk factors and assessment of renal function.

1.2.2. A minimum of two A_1C hemoglobin tests must be accomplished over a period of at least 3 months to determine if adequate control has been maintained.

1.2.3. Hemoglobin A_1C measured by liquid chromatography must be less than 8%.

1.2.4. A current retinal evaluation by an eye care specialist.

1.2.5. Dosage of oral hypoglycemics must effectively control the diabetes at less than the maximum dosage.

1.3. Injectable non-insulin agents require full FFD/WWD evaluation.

Section Q, Psychiatry and Mental Health

1. Conditions that are expected to result in persistent duty impairment (more than one year despite treatment), conditions associated with recurrent duty impairment (two or more episodes of duty impairment in 12 months), conditions that require continuing psychiatric or psychological support beyond one year (e.g. regular psychotherapy in order to function), and conditions requiring the use of lithium, anticonvulsants, or antipsychotics for mood stabilization all require a FFD/WWD evaluation.
2. These and all other non-temporary axis I diagnoses require a clinical evaluation to determine if the individual is suitable for deployment. Complex mental health conditions, conditions poorly defined or controlled, or those conditions in which appropriate documentation is not available will require an evaluation by an active duty mental health provider in order to determine deployability.
3. Medically straightforward, stable mental health conditions managed with a single medication may be evaluated by the RMU provider based upon civilian healthcare documentation. If, in the opinion of the reviewing reserve military provider, the condition is stable and the member is considered deployable, no active duty evaluation is required. However, the AFRC/SGP physician may direct such an evaluation if they believe it is required.

3.1. The clinical summary must clearly address the duration of any psychiatric condition, expected

permanence of the condition(s), how well controlled the condition currently is, the member's ability to function at home, in reserve environments, and in deployed settings, treatment recommendations, and a clear prognosis (see Attachment 15).

Section III: AFI 10-203, *Duty Limiting Conditions*
CHAPTER 1 – GENERAL PROVISIONS

1.2.3. For non-prior service enlistment applicants and for those prior service enlistment applicants who fall under the accession standards of DoDI 6130.03, the numerical designator "2" may be used only under the letter designators "H" for hearing and "E" for vision. Numerical designator "2" will not be used or accepted under letter designators "P", "U", "L", or "S" for these categories of applicants. Such use implies some limitation of function or performance and is not compatible with full qualifications for enlistment under AFI 48-123. P2, U2, L2 and S2 (or greater) requires submission of a package to HQ AFRC/SGP for waiver consideration. Prior service applicants and any member of the Individual Ready Reserve (IRR) with a 2 or 3 profile and who have been separated from any armed service for less than 6 months are evaluated under retention standards.
1.2.4. For prior service applicants who qualify for retention standards (less than 6 months break in service), the RMU will provide the Recruiter with a dated and signed SF Form 600 with the PULHES annotated and a printed copy of the most recent PHA.

1.3. Duty Limitations.

1.3.4. Duty Limiting Conditions/AF Form 469. Duty limiting conditions may or may not also require a PULHES entry and profiling with AF Form 422. However, all duty limiting conditions require the completion of an AF Form 469, Duty Limiting Condition Report.
1.3.5. Participation Waivers (PWs) for Reserve Personnel. PWs are a medical reflection of risk management; they are not driven by the line commander's desire for a member to participate in spite of a duty limiting or disqualifying condition. PWs are granted for certain medically disqualified personnel pending waiver, who are safe to participate in Inactive Duty Training (IDT) status at home station. HQ AFRC/SGP is the waiver authority for reservists requesting a waiver to AFI 36-2254, Volume I, *Reserve Personnel Participation.* This is the only mechanism for Assignment Availability Codes (AAC) 31 (Medical Deferment) and 37 (Medical Evaluation Board/Physical Evaluation Board) personnel to return from the no pay, no points status of AFI 36-2254 V1, para 1.6.3. The first recourse for participation is the prompt processing of a fitness for duty (FFD)/world-wide duty case (WWD). A PW should be an exception. This waiver allows participation at home station with a Duty Limiting Condition (DLC) (Code 31 or 37) prior to undergoing FFD/WWD processing, or recovering or being treated for a temporary mobility limiting condition. The only approved duty status for Reservists issued a PW is IDT for unit training assemblies (UTA), Active Duty Training (ADT) for annual tour (AT) at home station and orders for service connected medical appointments. Members will not be assigned duty away from home station and may not perform any other man-days or attend formal schools.

1.3.5.1. A PW may be requested via Electronic Case Tracking (ECT) The RMU or Military Treatment Facility (MTF) will draft a narrative summary with the member's name, rank, SSN, DOB and unit, authored by an appropriately credentialed military provider. The narrative summary will address the diagnosis, medications, current duty/fitness restrictions and limitations, prognosis and follow-up requirements. Sedating medications will not be waived. The summary should also include a requested duration (generally not to exceed120 days). The narrative summary should reflect the provider's best medical judgment. Cases should be uploaded into ECT. Local medical units may not issue PW on their own, with the exception of conditions noted in 1.3.5.4 below. A technician can forward the request as long as the requesting physician's name/signature block is included on the narrative summary.
1.3.5.2. When HQ AFRC/SGP grants a PW, the approval is loaded in ECT for the RMU with the following wording that will be added to the remarks section of the AF Form 469: "Individual is restricted from all military duties other than UTA, AT at home station and man-day orders for service connected medical appointments only. Member will not be assigned duty away from home station and may not perform any other man-days or attend formal schools. This waiver granted by HQ AFRC/SGP is valid until given date. The expiration date of the PW is

independent of the release date of restrictions and limitations noted on the AF Form 469 which should not be changed." No exceptions to these restrictions will be considered! Document the existence of the temporary PW on SF Form 600. Include a copy of the Form 469 in the FFD/WWD package.

1.3.5.3. Expiration of the PW is independent of, and may be prior to the release date established on the AF Form 469. Request renewal by forwarding updated medical information via ECT. The PW process is not intended to circumvent the need to expedite a FFD/WWD evaluation. A maximum of 3 PWs will be granted. Revocation of the PW can be made at any time, either locally or by HQ AFRC/SGP. HQ AFRC/SGP will be notified of any local revocation.

1.3.5.4. Limited authority for local PW. There are conditions which are clearly temporary and which are expected to resolve within a limited period of time. Local waivers for participation at home station for UTA or AT may be granted for a cumulative period not to exceed 180 days for the following conditions:

1.3.5.4.1. Simple fractures, strains and sprains of the extremities or back

1.3.5.4.2. Orthopedic surgery after which complete functional recovery is expected within 180 days

1.3.5.4.3. Other surgery after which complete functional recovery is expected within 180 days

1.3.5.4.4. Superficial dermatology procedures (melanoma excluded)

1.3.5.4.5. Minor biopsies

1.3.5.5. The conditions listed in 1.3.5.4.1. through 1.3.5.4.5. must require only an Assignment Availability Code (AAC) 31 (e.g., will resolve within 365 days or less). No waivers may be locally granted for any AAC 37 condition. HQ AFRC/SGP may revoke any local waiver that appears to require FFD/WWD evaluation for long-term disqualification.

1.3.6. Assignment Availability Codes (AAC) 31 and 37. In accordance with AFI 36-2254, V1, a Reserve member with an AAC "31" or Code "37" may not participate for pay or points. A "31" or "37" code may be levied at any time a Reserve member's medical/dental qualifications for worldwide duty are considered to be questionable pending further evaluation. The MSD identifies the more common medical/dental conditions which require a "37" code; however, this chapter is not all-inclusive. Any permanent or temporary medical/dental condition which, in the opinion of the military physician/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 a "31" or "37" code.

1.3.7. ALC-C Waiver Requests:

1.3.7.1. No permanent modifications to DLC's will occur during modification processing. Modification waivers will be considered on a case-by-case basis. Expeditious processing or re-adjudication of the FFD/WWD case is preferred over granting numerous temporary modifications.

1.3.7.2. HQ AFRC/SGP MUST review all requests for deployment waivers to the Area of Responsibility (AOR) or other gaining MAJCOM locations for those individuals on an ALC. All requests should be submitted to afrc.sgp@us.af.mil for review and forwarding to the appropriate MAJCOM/SG. All requests should be processed in accordance with (IAW) the USAFCENT/SG Medical Waiver Guide located on AEF online.

1.5. Duty limitations are managed IAW AFI 10-203 and documented on AF Form 469. All references to DLC refer to Assignment Availability Code "31" and "37" unless otherwise noted. The Chief of Staff of the Air Force 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 (DLCs). RMUs will route all accommodation request to HQ AFRC/SGP via ECT. This does not apply to ALC-C or non- compliance actions.

CHAPTER 2 - ROLES AND RESPONSIBILITIES

2.15. RMU responsibilities following Mobility Restriction DLC action on *non-duty related* medical/dental conditions:

2.15.4. FFD/WWD processing occurs IAW AFI 10-203, Chapter 5.

2.15.5. Initiate an AF Form 469 utilizing (ASIMS).

2.15.6. The "Physical Limitations/Restrictions" block on AF Form 469 will contain the following statement: "For MPF: Update Duty Status code (DS) “14”. Member may not participate for pay or point gaining activities”.
2.15.7. 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. With commander concurrence, the commander or designated representative will issue the form to the member. If the Commander non-concurs, follow procedures described in AFI 10-203, para 3.4.1.1. Only non-concurrence requires RMU notification. See AFI 10-203, Chapter 3 and Attachment 14 within this document for general guidance on mobility restrictions.
2.15.8. Ensure a copy of the Unit Commander Memorandum (Attachment 2c) is sent to the unit commander.
2.15.9. Forward a copy of the AF Form 469 to the local Military Personnel Flight (MPF).
2.15.10. Counsel the member on the process involved with evaluating his/her medical qualifications for WWD. For Code 31 individuals, see Attachment 1. For Code 37 individuals, see Attachment 2 of this CPM.
2.15.11. RMU responsibilities following MR DLC action on duty related medical/dental conditions—ensure that AF Form 348, LOD, has been initiated in the Electronic Case Tracking (ECT).
2.15.12. For clarity, AFI 48-123, para. 5.1.2. is reproduced here: “For ARC. Potentially disqualifying defects must first be determined if the condition is in the Line of Duty IAW AFI 36-2910, Chapter 3. If found to be In LOD, processing occurs through the Active Duty process in paragraph 5.1.1 of this instruction. If potentially disqualifying defects are not In LOD, FFD/WWD processing occurs IAW AFI 10-203, Ch 5.”

Chapter 3 - ESTABLISHING AND DISSEMINATING DUTY LIMITATIONS

3.2. Fitness Assessment Exemptions and Fitness Restrictions (FRs and FAEs).

3.2.3. Use the AF Form 469 to remove a member from components of the Fitness Assessment. Members must provide documentation from their civilian healthcare provider indicating their diagnosis, treatment plan, prognosis, fitness and duty limitations, current medications, and duration of limitations to be transcribed to an AF Form 469 per AFI 36-2905. The AF provider must interpret, assess, and determine the appropriate restrictions. The AF provider may modify or override any recommendations or restrictions following evaluation when exercising their best judgement IAW AFI 10-203 para 3.7. AF 469’s will NOT be issued to Reservists for fitness assessment exemptions and fitness restrictions not on EAD without supporting documentation from the member. If there is concern about testing the member prior to supporting documentation being available, the commander may allow the member to become non-current. Providers must be cognizant of the member’s Air Force Specialty Code (AFSC) when recommending any restriction.

3.2.3.1. There will be very instances of a fitness restriction without an accompanying duty restriction, even if the member works in a primarily administrative position. For example, if the provider feels the 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 what the member limitations.

3.2.3.2. Sample statements for an AF 469 with Physical Limitations/Restrictions:

3.2.3.2.1. No high impact activities with lower legs/feet.
3.2.3.2.2. No repetitive flexion/extension of the knees.
3.2.3.2.3. No high or low impact activities with legs.
3.2.3.2.4. No repetitive flexion or extension at the waist.
3.2.3.2.5. No prolonged standing or walking (X hours).
3.2.3.2.6. No lifting greater than X lb.s with right / left upper extremity.
3.2.3.2.7. May wear orthopedic boot.
3.2.3.2.8. May wear tennis shoes in uniform which meet athletic shoe uniform requirements in AFI 36-2905.
3.2.3.2.9. No-weight bearing on feet/must use crutches.
3.2.3.2.10. No running greater than X yards
3.2.3.2.11. No deployment.

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

3.2.3.4. IAW AFI 36-2905 para 5.2.2.3., for DLC's lasting greater than 31 days as annotated on AF Form 469, members are exempt from the full four component FA for 42 days after the expiration date of physical limitations to allow for reconditioning. For DLC's projected for 30 or fewer days, the FAE's will expire the same day as the FR's/DR's.

3.2.3.5. Fitness Assessment Exemptions expire on AF Form 469 release date

3.5.3. Pregnancy DLC Reports for Reserve Personnel.

3.5.3.1. Guidance on the participation of pregnant members can be found in AFI 36-2254 V1. Untrained assets will not be granted waivers to attend formal courses and schools.

3.5.3.2. Follow the fetal protection program requirements as directed in AFRCI 41-104.

3.5.3.3. Pregnant members in flying positions are managed IAW AFI 48-123, the MSD, and the Air Force Waiver Guide.

Section IV: AFI 48-145*, Occupational and Environmental Health Program*

4.4.2. Medical Surveillance Examinations. Occupational Examinations will be accomplished with the PHA. 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 at the link http://www.dtic.mil/whs/directives/corres/pdf/605505mp.pdf .

4.4.2.5. Firefighters. New fire fighter physical examination requirement can be found at https://kx.afms.mil/kj/kx2/OccupationalMedicine/Pages/firefighter.aspx . 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.

4.4.2.6. 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. This category will be used in lieu of military since their primary exposure to hazardous noise occurs during performance of their civilian job. Unit Reservists do not require periodic annual audiograms unless indicated medically or by engineering noise survey. In most circumstance Reservists that have incidental exposure to hazardous noise that does not exceed routine annual UTA days (i.e., >30 days) need not be tested. Recommend that fire fighters (i.e. TR, ART, and Title V Civilian Federal Employees) and Reserve members and CFE with impact noise exposure (i.e. Combat Arms Training & Maintenance personnel) receive initial, annual, and termination hearing tests regardless of 30 day rule. 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. Thirty day rule does not apply to Title V Civilian Federal Employees (i.e. those CFE who are not ARTs).

4.4.2.7. Hepatitis B. All service members are required to be immunized against Hepatitis B virus (HBV). AFI 44-108, *Infection Prevention and Control Program*, (1 Mar 12; IC 1, 16 Aug 12) provides guidance on management of the Medical Employee Health Program (MEHP) and the Hepatitis B virus (HBV) immunization requirement.

Section V: AFI 48-137, Respiratory Protection Program

2.14. PH or OMS.

2.14.6. For AFRC units with BE/PH positions at collocated installations (i.e. AD is host and AFRC units are tenant) the OMS responsibilities in 2.14.1 to 2.14.5. (above, and 5.2.3 below) for TR personnel 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 responsibilities in 2.14.1 to 2.14.5. (above, and 5.2.3 below) for TR

personnel shall be completed by the ground RMU and for Civilian Federal Employees, including Air Reserve Technicians, by the AFRC full-time BE/PH Office. (T-2)

2.14.6.1. The original intent of this section was to ensure that the process occurs. Paragraphs 2, 3, 4, and 5, require administration of medical records or an interface with civilian personnel, and are not expected to be part of the BE/PH office responsibilities.

2.14.6.2. Here is a suggested chain of events for an initial respiratory protection Medical Surveillance Examination (MSE) at an AFRC installation:

2.14.6.2.1. BE/PH office health risk assessment identifies an exposure profile during the industrial shop survey for a process which would require respiratory protection.

2.14.6.2.2. 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.

2.14.6.2.3. 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.

2.14.6.2.4. 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).

2.14.6.2.5. 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.).

2.14.6.2.6. 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.

2.14.6.2.7. 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.

2.14.6.2.8. 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.

2.14.6.2.8.1. If there is a "yes" response, the individual is referred back to the PLHCP with a complete OSHA questionnaire, and the additional required documentation for an appropriate medical evaluation.

2.14.6.2.8.2. 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."

2.14.6.3. 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 (i.e., 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."

2.14.6.4. Additional medical evaluations. At a minimum, the employer shall provide additional medical evaluations that comply with the requirements of this section if:

2.14.6.4.1. An employee reports medical signs or symptoms that are related to ability to use a respirator (29 CFR 1910.134(e)(7)(i)).

2.14.6.4.2. 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)).

2.14.6.4.3. 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)).

2.14.6.4.4. 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)).

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 a Duty Status Code 31.

2. I understand that while on a Code 31, I am considered medically disqualified for worldwide duty and may not participate in military duty for pay or points until after the Code 31 has been removed, or until a Participation Waiver (PW) is granted by HQ AFRC/SGP.

_____However, my medical provider does not believe my condition is currently suitable for a PW, and a request will not be submitted at this time. I may not participate for pay or points.

_____My medical provider believes that my condition may currently be suitable for a PW, and therefore a request will be submitted after receipt of appropriate medical information.

3. I understand that a PW, if any, is granted for short periods pending resolution or waiver of my condition, and would enable me to participate AT HOME STATION ONLY during UTAs and Annual Tour. I understand that man-days and off- station TDY are not permitted.

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. I understand that HQ AFRC/SGP must review my case to determine if I am medically qualified for restricted or worldwide duty.

5. I understand that a request for a PW will not be forwarded to HQ AFRC/SGP if I do not provide the required information to the (**name RMU**) within the allotted time. I also understand that refusal to provide requested information may result in administrative action and/or medical disqualification by HQ AFRC/SGP solely on the basis of available information.

6. I understand that a medical disqualification action by HQ AFRC/SG is not the final action to determine whether I may remain in the Air Force Reserve.

7. I understand that if HQ AFRC/SGP 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 **Date**

_____ _____

Signature of Briefer **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 **Date**

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 a Duty Status Code 37.
_____2. I understand that while on a Code 37, I am considered medically disqualified for worldwide duty and may not participate in military duty for pay or points until after the AAC 37 has been removed from my AF Form 469, *Duty Limiting Condition Report*.
_____3. I understand that the (### **RMU**) must prepare a medical evaluation package on me to forward to HQ AFRC/SGP 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 (### **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 HQ AFRC/SGP without this information if I do not provide it to the (### **RMU**) within the allotted time.
_____6. I understand that HQ AFRC/SGP must review my case to determine if I am medically qualified for worldwide duty.
_____7. I understand that a medical disqualification action by HQ AFRC/SG is not the final action to determine whether I may remain in the Air Force Reserve.
_____8. I understand that if HQ AFRC/SGP 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 may case forwarded to the PEB, the decision by HQ AFRC/SGP is final and my case will be forwarded to HQ AFRC/A1KK for separation action. I further understand that if found "medically disqualified" by HQ AFRC/SGP 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 (### **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 restricted for participation for pay or points pending evaluation of the information provided.

_____ _____
Signature of Member **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.

_____ _____
Signature of Member **Date**

ALTERATIONS RENDER THIS FORM VOID

ATTACHMENT 2a – Physical Evaluation Board (PEB) Fact Sheet

Any member of the Ready Reserve who is not on a call 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 or when directed by the Secretary concerned, i.e., Secretary of the Air Force (SAF). 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) located at Randolph AFB TX, and a Formal PEB (FPEB) located at Lackland 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 only "unfit" determinations. All "fit" determinations are final and may not be rebutted by the member.

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. A member may request an FPEB only if the member disagrees with an "unfit" finding of the IPEB. If a member disagrees with the recommendation of the IPEB and requests an FPEB hearing, 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. If the member disagrees with an "unfit" recommendation of the FPEB, the member or military counsel at member's request will submit a brief rebuttal stating reason for the disagreement. The case will then be forwarded to the Air Force Personnel Board (AFPB) for their review and appropriate action. The AFPB will review the case and may change the findings and recommended disposition of the FPEB. The AFPB acts on behalf of the SAF, all decisions by the AFPB 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 Date

ALTERATIONS RENDER THIS FORM VOID

ATTACHMENT 2b – 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 HQ AFRC/SGP. 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 a right to rebuttal on any "unfit" decisions made by the Informal and Formal PEBs. The Secretary of the Air Force Council (SAFPC) makes the final decision when a member rebuts an "unfit" decision from the FPEB. All decisions made by the SAFPC are final and I have no right to rebuttal. I understand that a "fit" determination may not be rebutted.
4. I further understand that if I am medically disqualified for worldwide duty by HQ AFRC/SGP and I am found "fit" by the PEB and returned to duty by direction of the Secretary of the Air Force my continued participation in the Air Force Reserve will be in a restricted status. HQ AFRC/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 HQ AFRC/SGP 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 Date

To facilitate timely and accurate notification of IPEB results, I understand, 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 2c – Unit Commander Memorandum Template

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 & SSAN**) is a member of your unit. (**He/She)** has been found to have a medical condition which does not meet the medical standards in AFI 48-123, Medical Examination and Standards. Subject member has been placed on a code "37" and restricted from Reserve participation for pay or points.

2. We will evaluate (**member's name**) medical condition and prepare (**his/her**) case for submission to HQ AFRC/SGP for their review and appropriate disposition on the member's medical qualification for worldwide duty (WWD). The member has been given (**enter number of days**) days to provide us with any medical documentation from (**his/her**) private healthcare provider which (**he/she**) may want the Air Force Reserve Command Surgeon to consider.

3. If the member is found medically disqualified for WWD, HQ AFRC/SGP will forward (**his/her**) case to HQ AFRC/A1BF for further processing.

4. If the member is retained, appropriate disposition instructions will be forwarded to us by HQ AFRC/SGP. We will relay this information to you, the member, and (**servicing MPF**)/Personnel Employment Element. If the decision is not to retain the member and the member requested review by the Physical Evaluation Board (PEB), (**his/her**) case will be forwarded to HQ AFPC/DPPDS for review by the PEB. The PEB will make a "fitness" determination only.

5. If the member is found medically disqualified for WWD but retained or found "fit" for duty by the PEB, the member will be placed in an Assignment Limitation Code (ALC) "C" status and restricted from OCONUS travel and CONUS bare base deployments or duties.

6. We have briefed this member on the medical aspects of this process and directed (**him/her**) to report to the MPF/ Personnel Relocation Element for a pre-separation briefing.

7. The member (**has/has not**) elected to have (**his/her**) case reviewed by the PEB for a "fitness" determination. (Delete item number 7 if information is not available.)

8. The (**name 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.

9. If you have any questions about the medical aspects of this process, my POC is (**name/phone number**).

(**signature of Reserve Medical Unit Commander**)

Attachmen
t: AF
Form 469

cc:
Memb
er
MPF/DPMSA (Personnel Employment Element

ATTACHMENT 3 – Certification of Refusal to Sign

To be used for Military Duty Fact Sheet, PEB Fact Sheet and /or PEB Election form

Member's Name:

SSAN:

(Initial and date any actual refusals below)

_____Member refused to sign Medical Evaluation for Military Duty Fact Sheet but was provided a personal copy on___.

_____Member refused to sign Physical Evaluation Board (PEB) Fact Sheet but was provided a personal copy on_____.

_____Member refused to make a PEB Election but was provided a personal copy of the Election form on _____.

_____ _____

Signature of Briefer **Date**

ATTACHMENT 4 – Request for Information Template

DATE

MEMORANDUM FOR *MEMBER'S NAME Mailing address*
FROM: *RMU with complete mailing address*
SUBJECT: Request for Information – *Rank, Last name, First name MI, - SSN*

1. Explain the action taken by the RMU *(i.e., "You have been found temporarily medically disqualified for continued worldwide duty as indicated on the attached AF Form 469.")* Advise the member that he/she has 60 days from the date of the memorandum to provide the RMU with the signed and dated ME Fact sheet, signed and dated PEB Election form and any supporting medical documentation from civilian or military medical sources. Advise the member to keep a copy of each of the forms for his/her records.

2. If the requested information is not received by the (name RMU) within the allotted time, your case will be submitted to HQ AFRC/SGP for review and appropriate action. Failure to complete, sign, date and return the PEB Election form to (name RMU) in the allotted time constitutes a waiver of your right to have your case reviewed by the PEB.

3. POC for this case its (POC name), DSN 123-4567, Comm. (123) 456-7890.

SIGNATURE BLOCK

cc: Member's Unit Commander
Attachments
1. AF Form 469
2. Medical Evaluation Fact sheet
3. PEB Election
4. PEB Fact Sheet

NOTE: Letter must 1) Explain what action the RMU has taken. 2) Advise the member of the 60-day requirement to return requested documentation. 3) Request the member sign and date each form. 4) Identify the POC and phone number at the RMU. 5) Paragraph 2 should not be changed – use as is. 6) List attachments. 7) Send a copy to the member's unit commander. 8) Keep a copy at the RMU.

ATTACHMENT 5 – Member Utilization Questionnaire Template

DATE

MEMORANDUM FOR **(servicing MPF/DPMSA)**
FROM: **(unit commander's organization, office symbol, and address)**
SUBJECT: Member Utilization Questionnaire, **(member's rank, name, and SSAN)**

1. Given the member's current medical condition and associated restrictions (as determined by the Medical Unit), how would return to duty impact his/her ability to perform duties? **Note: If you need more medical information to make your recommendation or have medical questions, you may contact the Medical Unit medical personnel involved in member's medical disqualification. We need you to make an informed recommendation. (Describe specific impact)**

2. Was member in military status when the medical condition was first diagnosed? **Yes/No**

3. Was the medical condition diagnosed while member was on regular active duty prior to joining the Air Force Reserve? **Yes/No Note: If yes, please have member provide a copy of the DD Form 214 to the medical unit processing the member's case.**

4. Is member assigned to a UTC-tasked, deployable position? **Yes/No**

5. Prior to placement on code 37 status was member working in Primary AFSC (Officers) or Control AFSC (Enlisted)? **Yes/No** If not, why not, and for how long?

6. Has member's illness/injury/condition affected his/her ability to satisfactorily perform duty requirements? **Yes/No** Can he/she work full shifts? **Yes/No**

7. Does the member have duty restrictions? **Yes/No** If yes**,** Please explain:

8. Prior to placement on code 37 status, did member miss work or any required military duty (UTAs, annual tours, deployments, or field exercises, etc.) because of this or any other medical condition, medical appointments or treatment? **Yes/No.** If so, how much and how frequently?

9. How would returning this member to duty impact your unit's ability to effectively accomplish the mission, given the member's current physical restrictions,? **(Describe specific impact.)**

10. Is your unit required to deploy or perform military duty under field conditions? **Yes/No.** If yes, how often?

11. In your opinion, can the member deploy with the unit, even in a limited status or to limited locations (i.e. collocated with a medical support facility?) and effectively accomplish duties? **Yes/No**

12. Is member pending administrative action or judicial/non-judicial punishment that could result in demotion or dismissal from the United States Air Force? **Yes/No** If yes**,** Please explain:

13. Is member in the Self-paced Fitness Improvement Program (SFIP)? **Yes/No** If yes**,** Please explain:

14. Given the member's current medical/physical restrictions, as determined by the Medical Unit, are there any Home Station Support, non-deployable positions in your unit, in the same AFSC? **Yes/No.** In other awarded (Primary, secondary, etc.) AFSC? **Yes/No/N/A.**

15. Is the member planning to separate/retire or have they applied to do so? **Yes/No** If applied, effective date is: _____

16. Is member motivated to overcome the condition or illness and to continue as a member of the Air Force Reserve? **Yes/No**

17. Is member in compliance with AFIs 36-2903 **(Dress and Personal Appearance of AF Personnel) Yes/No** and 10-248 (**Fitness Program)**, AFRC Sup 1 **Yes/No**? If no, please explain.

18. Please provide the grade, name, DSN/Commercial number and email address of the full-time person within the unit to contact for questions or further information.

19. In your opinion, what would be the optimal outcome for the **member**, your **unit** and the **needs of the Air Force**, and briefly, why? (some examples would be: return to duty, even with restrictions, return to duty but retrain to a less physically demanding career field commensurate with the member's limitations; separate/retire, etc.)

(Unit commander signature)

1st Ind, (Wing/RSG Commander) (***HQ Direct Reporting Units can combine below endorsement information into the above MUQ)***

1. I understand personnel medically disqualified for continued military duty by AFRC/SG and subsequently found "fit" by the Informal/Formal PEB may be a **non-deployable** resource and placed in **Assignment Limitation Code (ALC) "C", "X", or "Y" with some or all** of the following restrictions as determined by AFRC/SG and indicated on the AF Form 469: ***Reserve participation in unit training assemblies and annual tours at home duty station only; no duty assignments away from home station or under field conditions; may not perform man-days or attend formal schools***. **I understand the applicable restrictions levied by AFRC/SG are permanent and can only be waived by HQ AFRC/SG.**

2. I'm aware of the AFRC Command retention policy and the Command manning policy, and procedures are in effect to manage our non-deployable resource to ensure we meet our mission needs. The wing/RSG currently has__**(please provide total number)** personnel in Assignment Limitation Code "C", "X", or
"Y" with indefinite expiration dates (888888 or 08 Aug 3888 as applicable).

3. I concur/non-concur (**please select one)** with the unit commander and member's return to duty will/will not **(select one)** adversely affect the unit or wing mission.

(Wing/RSG commander signature)

ATTACHMENT 6 – IRILO Coversheet

INITIAL RILO COVER SHEET

DATE: _____
PATIENT'S LAST NAME: _____ FIRST NAME: _____ MI: ____
RANK: _____
SSAN: _____
DUTY AFSC: _____
POTENTIALLY UNFITTING DIAGNOSIS(ES) THAT REQUIRES EVALUATION FOR CONTINUED MILITARY SERVICE IAW SECTION & NUMBER LISTED IN MSD.

1. _____
2. _____
3. _____
4. _____
5. _____

CAN MEMBER PERFORM OCCUPATIONAL DUTIES? Yes___ No ___

PROGNOSIS:
_____
_____

ONGOING TREATMENT (include any hospitalizations, urgent care):
_____
_____
MEDICATIONS/DOSAGE:
_____
_____

RISK FOR SUDDEN INCAPACTIATION: Low: ___ Moderate: ___ High: ___

RECOMMENDED FOLLOW-UP INTERVAL:
3- mo.s ___ 4-mo.s___ 6- mo.s ___ Annual ___ Biennial ___

DAWG RECOMMENDATION: RTD C-1 C-2 C-3 DQ WWD

_____
DAWG Chair Signature

_____
DAWG Chair Printed Name, Rank

ATTACHMENT 7 – HIV Initial Notification Memorandum Template

MEMORANDUM FOR **MEMBER**
FROM:
SUBJECT: Notification to Return to (NAME **RMU**)

1. We request that you return to the (**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.

//SIGNED//

HIV designated physician

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 8 – Commander Notification Memorandum Template

MEMORANDUM FOR (**MEMBER'S UNIT COMMANDER**)
FROM:
SUBJECT: Positive HIV test results

1. (**Member's Name**) of your unit has tested positive for the HIV antibody. (**Gender**) has been sent the attached letter requesting that (**gender**) return to this facility to discuss the results of the laboratory test taken in conjunction with (**gender**) periodic physical exam. It is extremely important that (**gender**) contacts us as soon as possible and arrange for additional follow-up.

2. 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 make a determination 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, themember'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.**

//**SIGNED**//

RMU Commander

Attachment:
Member's memorandum (First Notification)

1st Ind, (**Unit's Name**) **Date**

Memorandum For (RMU Name)

I will not retain subject member.

Unit Commander's Signature

NOTE: This memorandum is used for notification of member's commander. Enclose it in an envelope stamped "Eyes Only (Unit Commander)."

ATTACHMENT 9 – HIV Second Notification Memorandum Template

MEMORANDUM FOR
FROM:
SUBJECT:

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.

. 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 in order to get the proper evaluation as soon as possible.

//SIGNED//

RMU Commander

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 10 – Flight Surgeon Skills Maintenance

MISSION ESSENTIAL TASK LIST

1. **Flying/Flying Training Activity**
   - 1.1. Aircrew Qualification and Continuation Training (AFI 11-2MDS_V1, usually Table 4.3 or 4.4)
   - 1.2. Other Aircrew training (CRFM, ORM, NVG, Stan Eval, etc)
   - 1.3. Flying Currency (including brief and debrief), IAW AFI 11-202V1
2. **Wing/Squadron Support**
   - 2.1. In-Flight Emergency and Physiological Incident Response
   - 2.2. Flight Surgeon Aeromedical Visits
     - 2.2.1. Flying Squadron Visits
     - 2.2.2. Air Traffic Control Facility Visits Life Support Shop Inspection BEE Shop Visit
     - 2.2.3. PH Facility Inspection or Field Activity
     - 2.2.4. Other Base Facility Visit (Simulator, Fire, Aircrew Flight Equipment shop, etc.)
   - 2.3. Flight Surgeon Aeromedical Briefings
     - 2.3.1. Safety Briefings to Wing or subordinate units
       - 2.3.1.1. ORM/CRM Briefings
       - 2.3.1.2. Fatigue management/circadian dysrhythmia
         - 2.3.1.2.1. Non-Pharm Counter-Fatigue Management (various modalities)
         - 2.3.1.2.2. Pharmacologic management
       - 2.3.1.3. Other Performance Enhancement Briefings (nutrition/exercise/etc.)
       - 2.3.1.4. Medical Considerations for Female Aircrew
       - 2.3.1.5. Aeromedical NOTAMS, etc
     - 2.3.2. Pre-/Post-Deployment Briefings
     - 2.3.3. Instrument Refresher Course Briefings
       - 2.3.3.1. Spatial disorientation
       - 2.3.3.2. NVG Training
     - 2.3.4. Other Base Operational Support/Prevention Briefings

3. **RSV Training**
   - 3.1. Operational Medicine
     - 3.1.1. Mishap Response
     - 3.1.2. Physiologic Incident Response and Analysis
     - 3.1.3. Travel Medicine
     - 3.1.4. Water and Food Vulnerability/Safety Assessment
   - 3.2. Human Performance Enhancement
     - 3.2.1. Human Factors Briefings
   - 3.3. Occupational Medicine and Industrial Hygiene
     - 3.3.1. Occupational Health Assessment
   - 3.4. Clinical Flight Medicine
     - 3.4.1. Aeromedical Summaries
   - 3.5. Prerequisite Certifications
     - 3.5.1. ATLS
     - 3.5.2. Clinical Flight Medicine Privileges
   - 3.6. Aeromedical Evacuation
     - 3.6.1. Medical Clearance for AE
4. **AEROSPACE MEDICINE ACTIVITY**

It is expected that over a 20-month period, activity covered by the items below can be demonstrated by local unit flight medicine sections via unit briefing attendance rosters, SGH/SGP section minutes, records of work output and/or individual flight surgeon training records.

   - 4.1. Clinical Capabilities
     - 4.1.1. Aerospace Medicine / Team Aerospace Activities
       - 4.1.1.1. Standardization of Aeromedical Programs/Issues
       - 4.1.1.2. Aerospace physiology Support (centrifuge, altitude chamber, etc)

4.1.1.3. Medical Vulnerability Inspections
4.1.1.4. Food/Water Vulnerability Inspections
4.1.1.5. Epidemiological Outbreak Investigations
4.1.1.6. Disease/Vector Control and other Force Protection Issues
4.1.2. Aeromedical Briefings to Medical Professional Staff
4.1.3. Acute, Routine, Wellness Patient Care
4.1.4. Pharmacologic Fatigue Management (Counseling, Dispensing, Tracking)
4.1.5. Travel Medicine: Interviews and Medication
4.1.6. Aerovac Consultation/Review/Clearance
4.1.7. Aeromedical Consultation/Review/Clearance
4.1.8. Aeromedical Staging Facility (ASF) Support
4.1.9. Aeromedical Evacuation
4.1.9.1. Patient Validation for AE Transport
4.1.9.1.1. Clinical Concepts
4.1.9.1.2. Use of TRAC2ES
4.1.9.2. Provision of Enroute Care
4.1.9.3. Combat Stress Management
4.1.10. Aeromedical Disposition Activities
4.1.10.1. Dispositions for Out of Clinic Consultations
4.1.10.2. Review Local Grounding Management/Aircrew SCL Programs
4.1.10.3. Waiver Work-Up, Summary Writing, and AIMWTS Entry
4.1.10.4. AMS Review and Certification as Local Waiver Authority
4.1.10.5. In-Flight Medical Evaluations of Aviators
4.1.10.6. Aeromedical Advice to other PCMs and Specialists
4.2. Occupational Medicine
4.2.1.1. Pre-Placement Examination Certification
4.2.1.2. Fitness for Duty and Disability Evaluations
4.2.1.3. Hearing Conservation Program/Fitness and Risk Evals
4.2.1.4. Evaluate and Prescribe Protective Equipment
4.2.1.5. Occupational Health Working Group
4.2.1.6. Safety Hazard Mitigation and Workplace Safety
4.2.1.7. Epidemiological Investigation of Occ Health Conditions
4.2.1.8. Occ Med Advice to other providers/base leadership
4.3. MEB, Profiling, and Special Program Dispositions
4.3.1.1. MTF Profiling Officer: Application of stds to indiv defects
4.3.1.2. MEB Case Work-up and Summary Writing
4.3.1.3. MEB Review and Approval
4.3.1.4. Clearances (Security, Overseas, etc.)
4.3.1.5. PRP Management and Chart Reviews
4.3.1.6. Medical Reporting Officer for Drug Screening Program
4.4. Emergency Preparedness and Responses
4.4.1. CBRNE Exercises and Responses
4.4.2. HAZMAT Exercises and Responses
4.4.3. Mass Casualty/MARE Exercises and Responses
4.4.4. Aircraft Mishap Exercises and Responses
4.4.5. Mishap Investigation: Medical Member of SIB/AIB
4.4.6. Search and Rescue (SAR) Support
4.4.7. Develop/Refine Emergency Response Plans (all types)
4.4.8. First Responder Training (all types)
4.4.9. Inspection/Inventory of Emergency Response Equipment
5. **Readiness Activities**
5.1. Pre-/Post Deployment Screening/Clearance
5.2. Deployment Planning and Logistics
5.3. Med Intel: Research, Analysis, Briefings

5.4. Site Survey or Advon Team Member
5.5. Operational Readiness Exercises/Inspections
5.6. Deployment/Field Communication System Familiarization
5.7. Air Transportable Clinic: inventory, setup, exercise

6. **Personnel, Leadership, Admin Activities**
6.1. Aerospace Medicine Sq/CC Duty
6.2. Chief of Aerospace Medicine (SGP) Duty
6.3. Supervision of Subordinates (EPRs, OPRs, admin etc)
6.4. Deployment Availability Working Group
6.5. Other Committee Meetings
6.6. Physician PAFSC and Flight Medicine CME attendance

7. **KNOWLEDGE BASE**

Operational flight surgeons should also work from the list below to ensure a working familiarity with subject matter areas applicable to their flying mission and platform.

7.1. Hyperbaric Treatment and Observation
7.2. HUD Tape Review
7.3. Threat Assessment: Directed Energy/Emerging weapons
7.4. R&D of Human Performance Enhancement Technologies
7.5. Aeromedical Capability Gap Analysis
7.6. Special Airlift Mission Support
7.7. Traumatic Stress Response (IAW 44-153)
7.8. Repatriation of POWs and Detainee Escort Missions
7.9. Joint Operations
7.10. Host Nation Liaison and Support/Humanitarian Ops
7.11. Interface with Government/Non-Government Orgs
7.12. Public Affairs: answer queries as Subject Matter Expert
7.13. Legal: Responding to Aeromedical legal Issues
7.14. Post-suicide support for Flying Units
7.15. Family Notification/Support following Death/Casualty

ATTACHMENT 11 – AFRC Flight Surgeon 48X3 Mission Qualification Training (MQT)

UPGRADE WORKSHEET

Rank/Name_____ Base _____ Residency/Specialty_____ Position # _____

	TASK	DATE	DATE	DATE	DATE	DATE
1	Complete RTU (AMPR 301)					
2	Aircrew/SERE/Life Support Training					
3	Credentialing					
4	Flying Sorties					
5	Current on all RSV for 48XX					
6	NVG Qualification (if applicable)					
7	USAF Fatigue Mgmt					
8	Potable Water Sampling					
9	AMC Attendance					
10	DAWG Attendance					
11	Waivers					
12	Occupational/Shop Visits					
13	PH/Food/Sanitation Inspections					
14	AF 1041 Review					
15	ASF Familiarization					
16	Aeromedical Evacuation Clearances					
17	Date of AMP graduation					

Explanations:

1. Graduation Certificate
2. Aircrew Training Folder must be completed and validated by the Squadron Training Office of the flight surgeon's unit of flying attachment – refer to AFI 11-2MDS-V3 FS training requirements - SERE survival, Life Support, FS test, altitude chamber, centrifuge, etc.
3. Credentialing must be completed for flight medicine practice.
4. Six flying sorties must be accomplished (minimum of three in primary aircraft and one night sortie).
5. Complete all RSV in MRDSS for assigned UTC and AFSC.
6. NVG Qualification (based on flying mission).
7. Complete AFI review of Counter-Fatigue Management Program and HAF Policy Letters on Go/No-Go.
8. One potable water sampling with BEE.
9. Six Aerospace Medicine Council (AMC) meetings must be attended.
10. Six Deployment Availability Working Group (DAWG) meetings must be attended.
11. Three flying/special duty waivers must be accomplished.
12. Occupational/Shop Visits: Occupational Health Working Group (OHWG) meeting and a shop visit (Life Support, Control Tower, or shop visit (Cat I or Cat II shop with respiratory protection with BEE))
13. PH/Food/Sanitation Inspections: two food/sanitation facility inspections with Public Health.
14. Six Grounding Management (AF Form 1041) review meetings must be attended.
15. Read AFI 44-165 Administering Aeromedical Staging Facilities (ASF).
16. Six mock air evacuation patient clearances with paperwork (AF Form 3899); review with local SGP.

Forward completed worksheet to HQ AFRC/SGP for review and recommendations.

Certified by:

Chief of Aerospace Medicine (SGP) (Printed Name, Signature, Date)

Assigned Squadron Commander (Printed Name, Signature, Date)

Approved by HQ AFRC/SGP for AFSC upgrade to 48X3 (Printed Name, Signature, Date)

ATTACHMENT 12 – 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 unit’s. 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, 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.

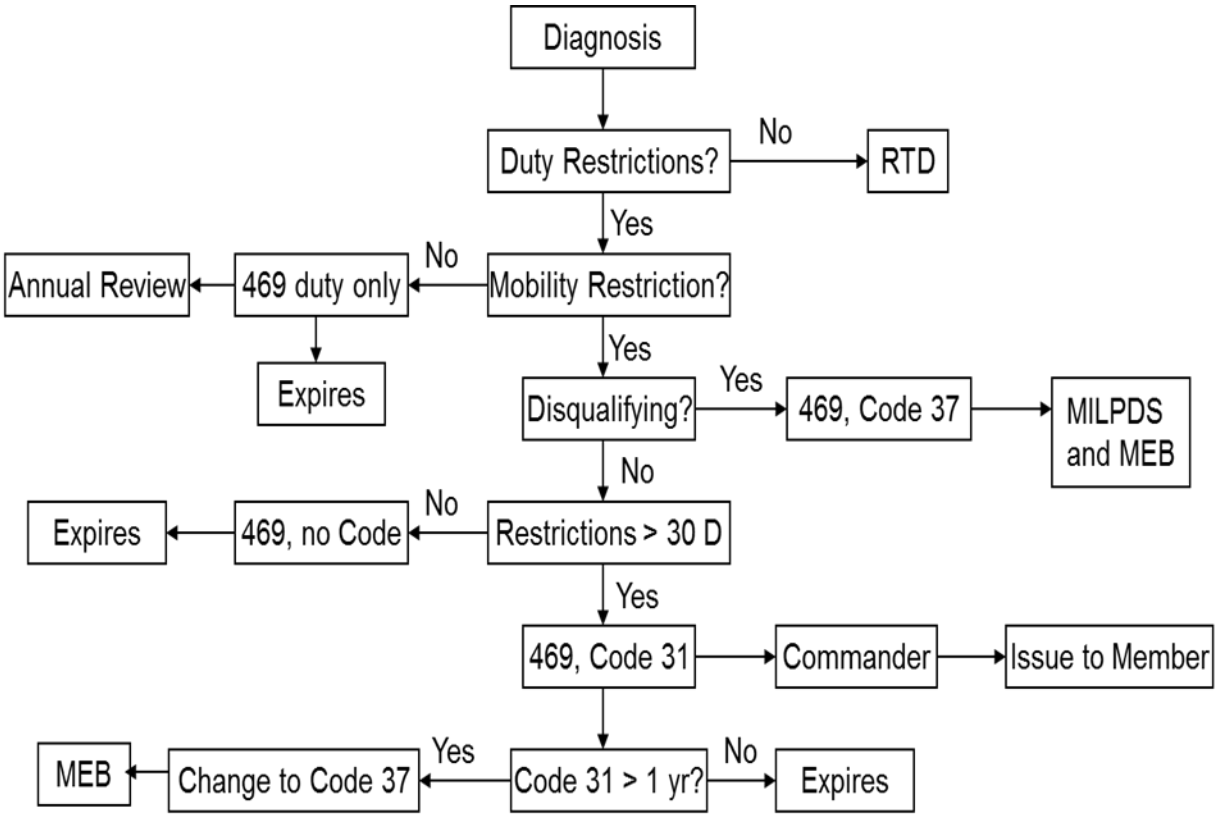
5. Affiliation Screen: When adding affiliations, enter all civilian places of employment using the “facility” button. Off duty employment is not applicable and will not be used.

6. Readiness Screen: Ensure the members UTC is put in the UIC/UTC field. Although not deployable, FFD/WWD 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 13 – AF Form 469 Duty Limiting Condition (DLC) Report Flow Chart



ATTACHMENT 14 – Narrative Summary Medical Template

DIRECTIONS: Write the Narrative Summary in paragraph format as you would a descriptive H & P, placing the information that is listed in the italicized outline in complete sentences within paragraphs under each heading. *Italics and outline format found below are for your guidance in using this template only.* ***Please delete any italicized directions and italicized alpha-numerics from the outline*** *after you fill in the Narrative summary information using sentence format, and before saving this NARSUM as an "add note".* ******A SAMPLE MEDICAL NARSUM IS FOUND AT THE END OF THIS TEMPLATE GUIDE******

******Before beginning, review the table listing required consults/exams/studies (attached-last page)***

(1) Demographics: *In order, list:*

(a) full Name, Rank, and SS#

(b) # years in service (if part of the years in service are reserve/guard, delineate how many for ARC/Active)

(c) Duty AFSC

(d) Current duty title and brief (sentence or two) synopsis of primary duties

(e) If any of the following apply, simply state "Member is currently_____" for: Reserves, Air National Guard, TDRL, Basic Military Trainee, Air Force Academy Cadet, USAF Officer attending initial AFSC training, or USAF Enlisted attending initial technical training.

(f) List whether or not member has approved retirement or separation date and give the date.

(g) Are there any administrative actions pending and, if so, what are they?

(2) History:

(a) Pertinent Past Medical History: *In "list" format: condition, year of onset, and state whether "resolved" or "active". Only list major diagnos(es) which would be a factor in determining a member's overall health for a "fitness for duty" decision. (Most "resolved" conditions aren't applicable).*

(b) Pertinent Past Surgical History: *In "list" format, give name and year of procedure.*

(c) Pertinent Family History: *List* ***ONLY*** *genetic, heritable disorders related to any condition for which the patient carries a related diagnos(es).*

(3) Current Medications: List both medications taken, and medications that have been prescribed and/or recommended that patient is not taking due to "noncompliance" or optional nature. Include dose/freq.

(4) HPI - Potentially Unfitting Diagnos(es): ***For each potentially unfitting diagnosis*** *as per AFI 48-123, Chapter 5 (or any other diagnosis which affects the member's ability to perform duties, deploy and/or places a significant burden on the government to either protect or maintain the member), include the following:*

(a) Diagnosis

(b) Month/year of initial onset

(c) What was member doing when injury or symptoms of illness occurred for the first time?

(d) Where was the member (geographical location name) when injury or symptoms of illness first occurred?

(e) Was this condition ever treated during a deployment and did it require an early return from deployment?

(f) Month/year of any hospitalization, ER, or acute care visit, ***in the last 24 months, related to this condition.***

(g) Current medications and/or other treatment modalities ***used to treat this or related conditions***

(h) Prior medications and/or treatment modalities tried, for this condition, and reason for discontinuation.

(i) If narcotics used, give dose, frequency, level of pain control, and history of narcotic use.

(j) Include pertinent positive and negative ROS for this condition/related conditions.

(k) If any condition existed prior to service, please list and tell if/how service has aggravated the condition

(5) Targeted Physical Exam: *Note the table (attached) for specific exam elements.*

*(a) Vital signs to include **measured** height and weight, with **calculated** **BMI.***
(b) Exam should not be lengthy—give a relevant exam that documents the pertinent positive and negative exam findings related to each potentially unfitting condition.
(c) If the member falls under a category in section (1)e above (for example, a Basic Military Trainee), make sure that orthopedic exams include range of motion studies (in degrees), strength, and function. For active duty, these studies will be conducted by the VA if DPAMM directs a full MEB.

(6) Ancillary Study Summary: *Note the table (attached) for ancillary requirements.*

(a) Pertinent Labs: *List pertinent positive and negative labs **ONLY.** Do not cut/paste groups of labs unless you delete those that are not directly applicable. Provide values over a continuum of time if they pattern a picture of decline or improvement, or unpredictable nature of condition.*

(b) Pertinent Rads: *Do not copy and paste the entire study. Give the name of study, the date, and a clear picture of the results (impression).*

(c) Pertinent Other: *refer to attached table for "other" requirements*

(7) Consult Summary: *Note the attached table. Provide **a short, succinct summary** of (a) pertinent findings, (b) diagnosis (c) prognosis and (d) recommended frequency of specialty follow-up for each consult. Since the consults will be attached to this NARSUM, only provide (a)-(d) for each consult in this NARSUM.*

(8) Current Restrictions: *Review AF 469 (must be reviewed as current during NARSUM completion) and list any specific duty restriction, list the diagnos(es) to which the restriction is linked, and the release date of each restriction. Make sure and comment whether the release date currently stated on the AF 469 truly reflects the date the condition is expected to resolve, or if it is just an administrative release date for a scheduled review. **We must know when you anticipate that the restriction will be removed, or if it is expected to be a long term and/or permanent restriction. Note: The AF 469 review of restrictions should not be older than 30 days. Please reflect your review in the "Restriction section" of the AF 469 and/or in the NARSUM via the following statement: "Provider reviewed restrictions and they are deemed accurate and appropriate on (date)." Signature required after the statement.***

(9) Line of Duty Determination (LOD): Reference AFI 36-2910 for (a) whether or not this is an Administrative LOD determination or (b) if this requires an AF Form 348 LOD determination. If AF Form 348 is required, ensure it is included with Initial RILO package.

(10) Occupational Impact: ***For each potentially unfitting condition, succinctly summarize: (a) whether or not condition limits the ability to perform duties and/or deploy, (b) the extent of the limitation(s) and (c) Admin LOD determination required or for injury, AF Form 348 needs to be included with IRILO?***

(11) Prognosis: ***For each potentially unfitting condition, state the prognosis for:***
(a) full or partial (if partial, state to what degree) recovery, or stabilized maintenance of chronic condition
(b) timeline for recovery or stabilized maintenance of chronic condition
(c) future treatments (surgeries, procedures, studies, etc.) and duration of expected requirements.
(d) list the anticipated annual frequency for each specialty requirement, and expected duration required.
***Remember to delete the italicized guidance prior to saving as an "add note" in AHLTA. Also, delete the attached table.*
*******All ARC cases require an AF Form 348, Line of Duty (LOD) determination. For Active Duty members AFI 36-2910, Chapter 1, Paragraph 1.5 states when an LOD is required.***

Diagnosis	*Required Consults*	*Required Studies/Info*
Asthma	*Pulmonology (ONLY if Complicated)*	*Spirometry (MCT or HC if diagnosis in doubt)*
Burns		*% BSA, ROM, Photographs of affected areas*
Collagen Vascular Disease	*Rheumatology*	
Arthritis	*Rheumatology*	
Fibromyalgia	*Rheumatology*	*Trigger point summary*
Coronary Artery Disease	*Cardiology*	*ETT, Echo or Cath, NYHA class*
Diabetes	*Endocrinology if Insulin Dependent*	*FBS, A_1C, Optometry or Ophthalmology*
Hearing	*ENT*	*Audiogram*
Eyes	*Ophthalmology*	*Visual Acuity and Visual Field exam*
Neuromuscular	*Orthopedics (PT if available)*	*ROM (percent), Strength, Function, EMG if appropriate*
Musculoskeletal	*Orthopedics (PT if available)*	*ROM (percent), Strength, Function*
Cancer (Brain)	*Oncology, neurosurgery, & psych*	*5 year prognosis*
Cancer (Skin)	*Dermatology*	*5 year prognosis*
Cancer (Head and Neck)	*ENT*	*5 year prognosis*
Cancer (renal or GU)	*Urology*	*5 year prognosis*
Cancer (other)	*Oncology*	*5 year prognosis*
Multiple Sclerosis	*Neurology*	*MRI, spinal tap*
Headache	*Neurology*	*MRI, Log with # prostrating HA's last 12 months*
Seizure	*Neurology*	*EEG, MRI, Log of seizure frequency*
Renal	*Nephrology*	*Lab progression over time*
Crohn's/Ulcerative Colitis	*GI*	*Scope/Biopsy, Log of flare freq & severity*
Psych	*MD/DO Psych review and cosign*	*Military & Social-Industrial Impairment*
TBI	*Neuropsychiatry*	*MRI, Military & Social-Industrial Impairment*

(12) Addendum (To be written after C&P exam reviewed by provider—make comment as to whether other claimed conditions are UNFITTING or NOT UNFITTING for military service):

SAMPLE: ***"****I have reviewed the C&P exam dated XX XXX XX performed by the Veteran's Administration Medical Examiner(s). The member has the following additional claimed conditions: Hysterectomy, Bilateral carpal tunnel, GERD, Costochondritis, Hypothyroidism, Cervicalgia, Left knee condition, Left elbow tendonitis, and Migraine headaches with aura.*

None of these conditions are unfitting IAW AFI 41-210 and AFI 48-123, as they do not interfere with the member's ability to perform the duties of his/her office, grade, rank or rating. The original narrative remains current and accurate when compared to the member's VA exam. ( ) No updates are required. ( ) The following updates/clarifications are being made:……"
//Signed//
*** DATE SIGNED ***

ATTACHMENT 15 – Narrative Summary Psych Template

IDENTIFYING DATA:

Name:	SSN:	
Age:	Marital Status:	Race:
Military Status/Branch:	Rank:	Years of Service:

Note: List whether member has approved retirement/separation date and give the date.

"Prior to interviewing the service member (SM), Provider discussed the purpose of the evaluation as a fitness for duty assessment, the limits of confidentiality, that they WOULD/WOULD NOT be his treating physician, and that a written report would be submitted to the MEB/PEB to determine fitness for military duty. SM expressed understanding of these issues and agreed to proceed. Sources of information include:_____, that were deemed sufficient to make conclusions with reasonable clinical certainty".

ADVISEMENT AND WARNING

(*Usual non-confidentiality warning*)

REFERRAL SOURCE AND CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

(Concise and relevant. Summarize symptoms and behavior, especially work-related)

PSYCHIATRIC PAST HISTORY:

(*Prior symptoms, behavior, treatment and response; careful history of EPTS conditions)*

FAMILY HISTORY OF PSYCHIATRIC ILLNESS:

(First and second degree relatives, esp. history of suicide, substance abuse, legal problems)

PAST MEDICAL HISTORY:

(Relevant to mental symptoms: TBI, seizures, trauma; as well as unfitting medical diagnoses)

CURRENT MEDICATIONS:

(For medical and mental diagnoses—Reviewed and entered by prescribing provider)

SUBSTANCE USE/ADAPT:

PSYCHOSOCIAL HISTORY:

(No novel please; summarize relevant background for context)

MILITARY HISTORY:

(AFSC and Job title/description, call CC for input re: work function and risk to SM and mission)

PHYSICAL EXAM:

(*Summarize relevant PCM examination: entry by privileged medical provider)*

MENTAL STATUS EXAMINATION:

(Current MSE, and contrast w/ presentation across time and other examiners)

PSYCHOLOGICAL TESTING:

(Neuro-psych consult required for all TBI MEBs) *(Brief summary of relevant conclusions)*

CONSULTATIONS:

(Summarize findings of neuro, other medical consults related to duty fitness)

LABORATORY/RADIOLOGICAL DATA:

(Brain MRI required for all TBI MEBs)

HOSPITAL/OUTPATIENT TREATMENT COURSE:

(Summarize hospitalizations, locations, dates, outcome in bullet form)

DIAGNOSES:

Axis I – *(Axis I diagnoses can be either 'unfitting' (reason to discharge) or 'not-unfitting' (retain). State clearly which are/are not unfitting, and why; state specific duty impairments.*

Axis II – *(Personality Disorders are PEB 'Category III Unsuiting' conditions, for admin separation)*

Axis III – (*MC or NC writer determine from PCM notes or discussion)*

Axis IV – *(Military Social Stressors, ie PTSD triggers, deployment, family separation)*

Axis V – *GAF: Now and HIPY*

PREMORBID PREDISPOSITION:

(Genetic and psychological resilience/adaptation to military life prior to and after illness)

IMPAIRMENT FOR MILITARY SERVICE:

(C*omment specifically on worldwide duty and deployment/combat impairment—for impairment, –no impairment, -- minimal, --moderate, and –marked are the only terms used)*

SOCIAL AND INDUSTRIAL IMPAIRMENT:

*(Comment on adaptation to **non-military** work, school, family, social relationships—for degree of impairment, use the evaluee's current impairment, and state the projected impairment as --Total, --Severe, --Considerable,--Definite,--Mild or –None are the only terms used) .*

LINE OF DUTY DETERMINATION

Reference AFI 36-2910 for (a) whether this is an Administrative LOD determination or (b) if this requires an AF Form 348 LOD determination. If AF Form 348 is required, ensure it is included with Initial RILO package.

DUTY RESTRICTION REPORT (AF Form 469)

(All MEBs are no-Deploy/no-PCS. State other specific military duty limits: Driving? Arming? Security Clearance? Special Duty? Fly/PRP? Complete a 469 and keep current during MEB)

PROGNOSIS AND RECOMMENDATIONS:

(State ' competent for pay and records', danger to self or others, intensity/duration treatment required to maintain (XXX) level of function. Function is/is not compatible with rigors of military service.

(SIGNED)

*******DATE SIGNED********

GLOSSARY

A_1C – glycosylated 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 and 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, and 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
DAWG – Deployment Availability Working Group
DLC – Duty Limiting Condition
DOEHRS-IH – Defense Occupational and Environmental Health Readiness System–Industrial Hygiene
DOEHRS-HC – Defense Occupational and Environmental Health Readiness System–Hearing Conservation
DR – Duty Restriction
DS – Duty Status
ECG – Electrocardiogram (see EKG)
ECT – Electronic Case Tracking system
EKG – Electrokardiogram (see ECG)
EMS – Emergency Medical Services
FA – Fitness Assessment
FAA – Federal Aviation Administration

FAE – Fitness Assessment Exemption(s)
FFD – Fitness for Duty
FM – Flight Medicine
FOMC – Flight and 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
I-RILO – 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 AFI 48-123)
MSE – Medical Surveillance Examination
MTF – Military Treatment Facility
MUQ – Member Utilization Questionnaire
NARSUM – Narrative Summary
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 and 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
PW – Participation Waiver
R&D – Research and Development
RILO – Review In Lieu Of (Medical Evaluation Board)
RMU – Reserve Medical Unit
RPP – Respiratory Protection Program
RSG – Regional Support Group
SABC – Self-Aid and Buddy Care
SAF – Secretary of the Air Force
SAMMC – San Antonio Military Medical Center
SAR – Search and Rescue
SCL – Soft Contact Lens
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 And Command and Control Evacuation System
TST – Tuberculin Skin Test
UPT – Undergraduate Pilot Training
UTA – Unit Training Assembly
UTC – Unit Task Code
WWD – World Wide Duty