IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

Brock Stone, et al., Plaintiffs, v. Donald J. Trump, et al., Defendants.	Case No. 1:17-cv-02459-MJG

DECLARATION OF MARIANNE F. KIES IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISSOLVE THE PRELIMINARY INJUNCTION

I, MARIANNE F. KIES, depose and say as follows:

1. I make this declaration in support of the remedies and relief sought by Plaintiffs in this case. The following facts are based on my own personal knowledge, except those stated upon information and belief, and as to all such facts stated upon information and belief, I am informed and believe that the same are true.

2. I am an attorney with Covington & Burling LLP, and I represent Plaintiffs in this action.

3. Attached hereto as "Exhibit 1" is a true and correct copy of an April 12, 2018 Palm Center article titled, "Army Chief of Staff Testimony Contradicts Pentagon Report on Transgender Troops."

4. Attached hereto as "Exhibit 2" is a true and correct copy of a June 30, 2017 article written by Deirdre Shesgreen in the Springfield News-Leader, titled "Hartzler Wants to Ban Transgender Military Recruits."

5. Attached hereto as "Exhibit 3" is a true and correct copy of an August 23, 2017 Powerpoint titled, "All Things G-1 - Update to VCSA" bearing the Bates range USDOE00124434–62.

6. Attached hereto as "Exhibit 4" is a true and correct copy of a September 14, 2017 memorandum titled, "Terms of Reference - Implementation of Presidential Memorandum on Military Service by Transgender Individuals" bearing the Bates range USDOE00000442–43.

7. Attached hereto as "Exhibit 5" is a true and correct copy of a document produced by Defendants in the parallel *Doe, et al. v. Trump, et al.*, No. 17-1597 (D.D.C.) case bearing the Bates range USDOE00081113–16.

8. Attached hereto as "Exhibit 6" is a true and correct copy of a March 29, 2018 transcript of a Department of Defense Press Briefing titled, "Department of Defense Press Briefing By Pentagon Chief Spokesperson Dana W. White In The Pentagon Briefing Room."

9. Attached hereto as "Exhibit 7" is a true and correct copy of a March 25, 2018 Think Progress article titled, "Pence secretly drafted Trump's latest transgender military ban."

10. Attached hereto as "Exhibit 8" is a true and correct copy of a March 30, 2018 Washington Blade article titled, "Joint chiefs not briefed before Trump went public with trans military ban."

11. Attached hereto as "Exhibit 9" is a true and correct copy of a Powerpoint bearing the Bates range USDOE00101839–45.

12. Attached hereto as "Exhibit 10" is a true and correct copy of a March 27, 2018 Palm Center article titled, "26 Retired General and Flag Officers Oppose Trump Transgender Military Ban."

13. Attached hereto as "Exhibit 11" is a true and correct copy of a March 29, 2018 Washington Blade article titled, "DOD appears to contradict White House on process for trans military ban."

14. Attached hereto as "Exhibit 12" is a true and correct copy of a April 28, 2010 Department of Defense Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services."

15. Attached hereto as "Exhibit 13" is a true and correct copy of a November 16, 2017 Association of the United States Army ("AUSA") article titled, "Punching Through Barriers: Female Cadets Integrated into Mandatory Boxing at West Point."

16. Attached hereto as "Exhibit 14" is a true and correct copy of a January 2009 United Kingdom Ministry of Defence Policy "for the Recruitment and Management of Transsexual Personnel in the Armed Forces."

17. Attached hereto as "Exhibit 15" is a true and correct copy of an October 1, 2016 Department of Defense Instruction 1300.28, "In-Service Transition for Transgender Service Members."

18. Attached hereto as "Exhibit 16" is a true and correct copy of a January 25, 2018 Declaration. of Adm. Michael Mullen filed by Defendants in the parallel case *Karnoski v. Trump*, No. 2:17-cv-01297-MJP, ECF 148 (W.D. Wash. Jan. 25, 2018).

19. Attached hereto as "Exhibit 17" is a true and correct copy of an April 19, 2018 The Hill article titled, "Navy, Marines chiefs say no morale issues with transgender troops."

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 23rd day of April, 2018.

Marianne F. Kies (Bar No. 18606)

EXHIBIT 1

PALM CENTER
BLUEPRINTS FOR SOUND PUBLIC POLICY

APRIL 12, 2018

Army Chief of Staff Testimony Contradicts Pentagon Report on Transgender Troops

General Milley: "Precisely zero reports of issues of cohesion, discipline, morale"

SAN FRANCSICO, CA – Army Chief of Staff General Mark Milley today called into question a key claim of the Defense Department's recent report on transgender military service: ***that allowing transgender service risks undermining cohesion, privacy, fairness and safety.***

Asked by Senator Kirsten Gillibrand if he had heard of any problems with unit cohesion arising from open transgender service, Gen. Milley responded, **"I have received precisely zero reports of issues of cohesion, discipline, morale and all those sorts of things."**

Palm Center Director Aaron Belkin called Gen. Milley's remarks significant**. "It is telling for the Army Chief of Staff to acknowledge there have been 'zero' problems with cohesion, discipline or morale just weeks after a DoD report, ostensibly based on months of research, insisted that transgender troops pose a risk to cohesion, discipline and morale."**

The Defense Department report called into question the medical fitness of transgender troops, but the American Medical Association, American Psychological Association, American Psychiatric Association and retired U.S. Surgeons General have stated that the Pentagon's medical data and reasoning are misleading and unpersuasive.

An excerpt of the exchange between Sen. Gillibrand and Gen. Milley:

Senator Kirsten Gillibrand: Are you aware of any problems with unit cohesion arising… Have you [heard] anything about how transgender service members are harming unit cohesion?

General Mark Milley: No, not at all. We have a finite number. We know who they are and it is monitored very closely because I am concerned about that and want to

make sure that they are in fact treated with dignity and respect and no, I have received precisely zero reports of issues of cohesion, discipline, morale and all those sorts of things. No.

###

PRESS CONTACT

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ABOUT THE PALM CENTER

The Palm Center is an independent research institute committed to sponsoring state-of-the-art scholarship to enhance the quality of public dialogue about critical and controversial issues of the day.

For the past decade, the Palm Center's research on sexual minorities in the military has been published in leading social scientific journals. The Palm Center seeks to be a resource for university-affiliated as well as independent scholars, students, journalists, opinion leaders, and members of the public. For more information, see palmcenter.org

IMPLEMENTATION UNIT COHESION

Featured Research and Press Releases

PRESS RELEASE

Palm Center Statement on American Medical Association Letter of Criticism to Defense Secretary Mattis

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PRESS RELEASE

Palm Center Statement on Defense Department Refusal to Explain Transgender Ban

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PRESS RELEASE

Former Surgeons General Debunk Pentagon Assertions about Medical Fitness of Transgender Troops

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EXHIBIT 2

Hartzler wants to ban trans military recruits

Springfield News-Leader (Missouri)

June 30, 2017 Friday, 1 Edition

Section: NEWS; Pg. A6

Length: 1093 words

Byline: By, Deirdre Shesgreen, USATODAY

Body

"She's trying to reinstate 'don't ask, don't tell' for transgender troops and all of the research shows that 'don't ask don't tell' hurt military readiness and that inclusive policy, by contrast, works."

Aaron Belkin

Director of the Palm Center, a nonprofit group that advocates for transgender troops

WASHINGTON - Rep. Vicky Hartzler wants the Defense Department to kill a policy that would allow the military to enlist transgender individuals - a move she says would protect the Pentagon but that transgender-rights advocates say is misinformed and offensive.

The hotly debated policy is set to go into effect July 1, although Defense Secretary Jim Mattis may delay the implementation.

On Wednesday night, Hartzler, R-Harrisonville, offered an amendment to a sweeping must-pass defense policy bill that would have blocked the policy from taking effect. She eventually withdrew her proposal, saying she wanted to give the Pentagon "an opportunity to address this problem internally."

But if the Defense Department goes ahead with recruiting transgender individuals, Hartzler suggested she would revive her efforts on the House floor.

"It would degrade our readiness and waste precious defense dollars," Hartzler said in an interview Thursday.

She argued the move would force taxpayers to foot the bill for the "high medical costs" of transition surgery and related health care services. And she questioned whether transgender enlistees would be ready to serve, saying anyone undergoing such a procedure requires lengthy recovery time.

But advocates say Hartzler is using inaccurate information to push a discriminatory agenda.

"Pretty much everything she said was fabricated," said Aaron Belkin, the director of the Palm Center, a nonprofit group that advocates for transgender troops.

"Transgender troops have been serving successfully for the past year, so it's not clear why she would want to go back," he said. "She's trying to reinstate 'don't ask, don't tell' for transgender troops and all of

the research shows that 'don't ask don't tell' hurt military readiness and that inclusive policy, by contrast, works."

The law known as "don't ask, don't tell" banned openly gay and lesbians from enlisting and serving in the American armed forces. Congress repealed the law in 2010, but that rollback did not extend to transgender individuals.

Belkin and other transgender advocates pointed to a study by the Rand Corp., which found that transition-related health care costs are relatively low. At the upper limit, the Rand study concluded, less than 0.1 percent of the total military force "would seek transition-related care that could disrupt their ability to deploy."

Hartzler said that study was "flawed," and her staff conducted their own research using other sources.

"This is a threat" to troop morale and the Pentagon's finances, she said. Asked whether she would support allowing transgender individuals who had already undergone surgery to enlist, Hartzler said no.

"There still are reasons that it is a detriment to readiness and retention and morale, even if they're not involved in the transition process," Hartzler said. She argued that transgender individuals were likely to have greater ongoing health care needs and need mental health care treatment.

Plus, she said, there are privacy concerns involved with allowing transgender enlistees to shower and sleep in the same quarters as cisgender military personnel. Cisgender is a term for people whose gender corresponds to the sex they were assigned at birth.

"That's going to be very concerning, especially for female soldiers," she said.

In 2016, then-Defense secretary Ash Carter rescinded the ban on transgender troops, allowing those already in uniform to continue to serve and giving the military's service branches one year to develop a policy for recruiting transgender individuals and commissioning transgender officers.

The Army has been conducting compulsory transgender sensitivity training for soldiers and civilians. But at the same time, Army leaders were seeking a two-year delay in implementing the policy, while the Marine Corps wanted a one-year delay.

A military spokesman did not respond to an email seeking comment, but Mattis is expected to make a decision on the services' requests for a delay as soon as Friday.

Hartzler suggested that transgender individuals would be a burden to the military and create a "double standard" because people with "lesser physical issues," such as flat feet, are often rejected.

"Currently we refuse entrance into our armed forces for lesser physical issues, such as flat feet, bunions, asthma, and sleep walking," Hartzler said. "I had a constituent denied entrance into the JAG program because she had a bunion, yet accession standards are set to be modified to allow transgendered individuals into a military where they will be unable to fully serve. This is a senseless and highly unfair double standard."

Belkin said that was a "red herring." He said recruiters will not enlist someone who requires surgery for anything, whether a heart condition or a gender disorder.

To be eligible for enlistment, a recruit has to be stable in their gender for 18 months and fit to serve. Although each service branch has its own standards, generally recruits cannot have any medical or physical conditions that would require excessive lost service time for treatment or hospitalization.

Belkin said Hartzler's example of her constituent was "offensive" because it suggests that person was rejected for a trivial reason, when in fact that person was rejected because he or she probably cannot wear military footwear or run, jump or march.

Sarah Warbelow, legal director for the Human Rights Campaign, an advocacy group for gay, lesbian and transgender rights, called Hartzler's amendment "outrageous" and argued it would crimp the military's ability to recruit top-notch talent.

"It's an attempt to undermine the readiness of the military," not improve it, she said.

Hartzler said she wants Mattis to rescind the policy, not just delay its implementation. She would not say what she will do if he doesn't nix the scheduled policy change.

"I feel confident that he will see this is not good for our nation's readiness," she said.

Contributing: USA TODAY reporter Tom Vanden Brook

"She's trying to reinstate 'don't ask, don't tell' for transgender troops and all of the research shows that 'don't ask don't tell' hurt military readiness and that inclusive policy, by contrast, works."

Aaron Belkin

Director of the Palm Center, a nonprofit group that advocates for transgender troops

Load-Date: June 30, 2017

End of Document

EXHIBIT 3

All Things G-1

Update to VCSA

23 August 2017

Agenda

- DMPM (Briefers: BG Calloway/COL Turner)
  - **Update:** Increase Total Army Endstrength
  - **Information:** Military Accessions Vital to the National Interest (MAVNI)
  - **Information:** Transgender (TG) Personnel
- TBAI (Briefer: COL Johnson)
  - **Update:** IPPS-A
- ARD (Briefer: Mr. Lane)
  - **Update:** Commander's Risk Reduction Dashboard
- PR (Briefer: Mr. Lock)
  - **Update:** Blended Retirement – How do we Educate 100% of the Force?
- HSI Exposition
  - **Information:** Invitation to attend

DMPM Topics - Agenda

- Increase Total Army End Strength (IES) – FY17 Status & FY18 Planning
- Military Accessions Vital to the National Interest (MAVNI) – Current Status
- Transgender Personnel (TG) – Policy Status & Attrition

Transgender Personnel

Policy & Attrition Status

Transgender Personnel – as of 7 August 2017

- **Total Personnel (108):** 77 RA, 13 USAR, & 18 ARNG
- **Enlisted (88):** 91% attrite by end of FY21 (80 of 88)
- **Officer/WO (20):** no clear end dates; separations occur due to promotion non-selection, attrition, elimination, and retirement

•108 Total Transgender Personnel:

	Trans-Female	Trans-Male	Total	COMPO		
				RA	AR	NG
OFF	9	8	17	12	2	3
WO	1	2	3	2	0	1
ENL	44	44	88	63	11	14
TOT	**54**	**54**	**108**	**77**	**13**	**18**

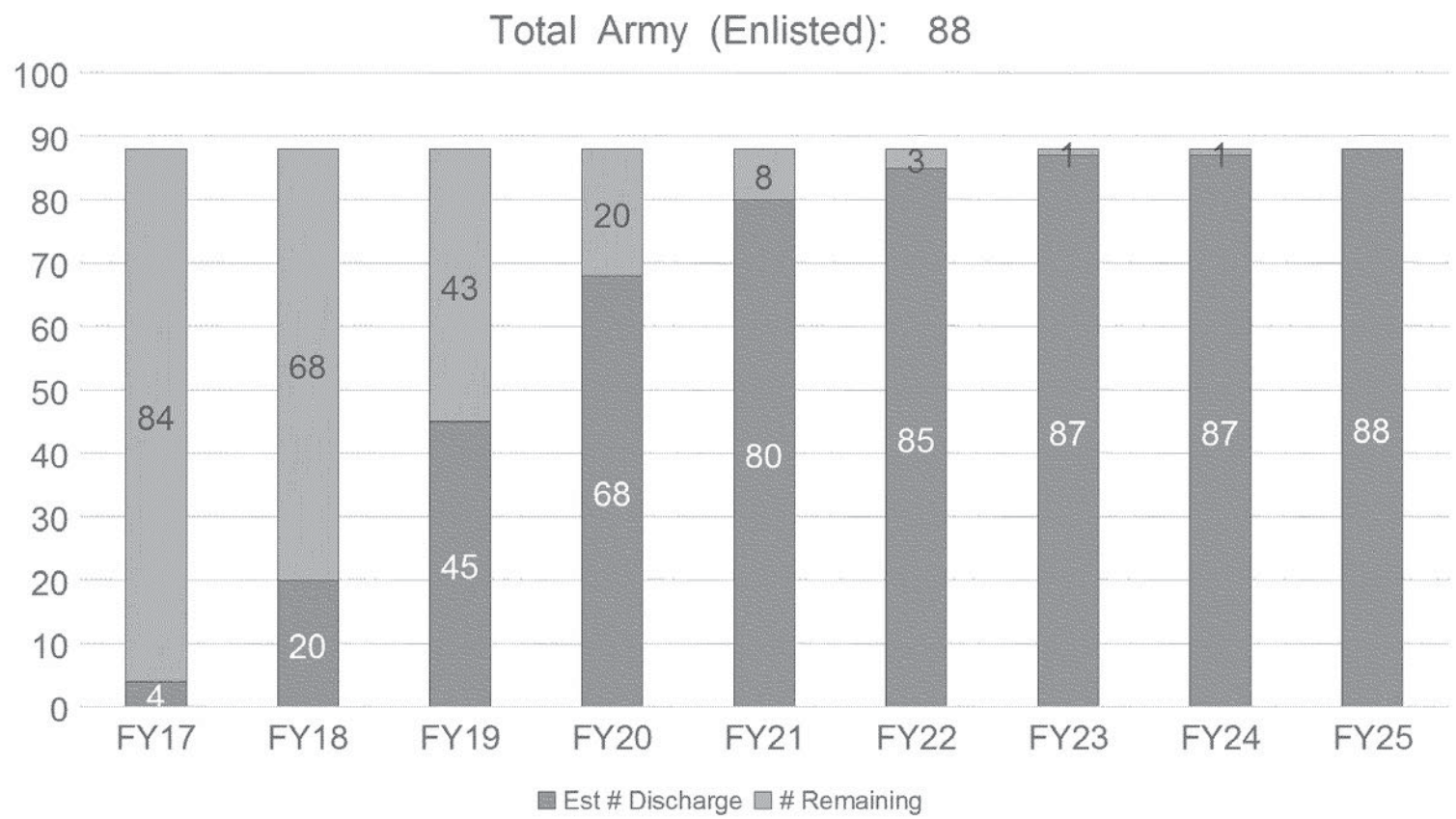
•50 with Gender Marker Changes:

	Trans-Female	Trans-Male	Total	COMPO		
				RA	AR	NG
OFF	5	4	9	5	1	3
WO	1	2	3	2	0	1
ENL	25	13	38	23	6	9
TOT	**31**	**19**	**50**	**30**	**7**	**13**

•58 pending Gender Marker Changes:

	Trans-Female	Trans-Male	Total	COMPO		
				RA	AR	NG
OFF	4	4	8	7	1	0
WO	0	0	0	0	0	0
ENL	19	31	50	40	5	5
TOT	**23**	**35**	**58**	**47**	**6**	**5**

Transgender Attrition - Status Each FY – Total Army ENL: 88



Reenlistment Category	AC	AR	NG	Total	%
Initial Term	30	5	2	37	42%
Mid Career	18	5	6	29	33%
Careerist	15	1	6	22	25%
Total	63	11	14	88	100%

- 88 Transgender RA Enlisted Soldiers
- 45 in Reenlistment window thru FY19
- Majority (80 of 88) attrite by end of FY21

Transgender Officers / Warrant Officers (WO): 20

- Failure to advance and natural attrition are the primary force shaping tools
- Officers may be eliminated for:
  - Substandard duty performance or derogatory information
  - Misconduct, moral/professional dereliction, interests of national security
- Probationary Officers may be separated without a Board of Inquiry

RA	Trans-Female	Trans-Male	Total	Probationary?	
				Yes	No
OFF	5	7	12	4	8
WO	1	1	2	1	1
TOT	**6**	**8**	**14**	**5**	**9**

RC	Trans-Female	Trans-Male	Total	Probationary?	
				Yes	No
OFF	3	2	5	2	3
WO	0	1	1	0	1
TOT	**3**	**3**	**6**	**2**	**4**

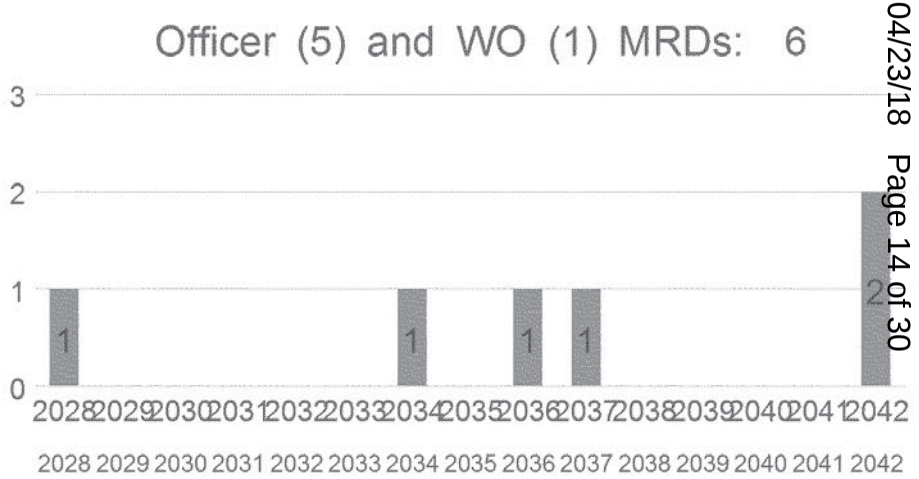


EXHIBIT 4

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

9/14/17

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
COMMANDANT, U.S. COAST GUARD
DEPUTY CHIEF MANAGEMENT OFFICER
CHIEF, NATIONAL GUARD BUREAU
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
DIRECTOR OF COST ASSESSMENT AND PROGRAM EVALUATION
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
DIRECTOR OF OPERATIONAL TEST AND EVALUATION
CHIEF INFORMATION OFFICER OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARY OF DEFENSE FOR LEGISLATIVE AFFAIRS
ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
DIRECTOR OF NET ASSESSMENT
DIRECTOR, STRATEGIC CAPABILITIES OFFICE
DIRECTORS OF DEFENSE AGENCIES
DIRECTORS OF DOD FIELD ACTIVITIES

SUBJECT: Terms of Reference - Implementation of Presidential Memorandum on Military Service by Transgender Individuals

Reference: Military Service by Transgender Individuals – Interim Guidance

I direct the Deputy Secretary of Defense and the Vice Chairman of the Joint Chiefs of Staff to lead the Department of Defense (DoD) in developing an Implementation Plan on military service by transgender individuals, to effect the policy and directives in Presidential Memorandum, *Military Service by Transgender Individuals*, dated August 25, 2017 ("Presidential Memorandum"). The implementation plan will establish the policy, standards and procedures for service by transgender individuals in the military, consistent with military readiness, lethality, deployability, budgetary constraints, and applicable law.

The Deputy Secretary and the Vice Chairman, supported by a panel of experts drawn from DoD and the Department of Homeland Security (DHS) ("Panel"), shall propose for my consideration recommendations supported by appropriate evidence and information, not later than January 15, 2018. The Deputy Secretary and the Vice Chairman will be supported by the Panel, which will be comprised of the Military Department Under Secretaries, Service Vice Chiefs, and Service Senior Enlisted Advisors. The Deputy Secretary and Vice Chairman shall

designate personnel to support the Panel's work to ensure Panel recommendations reflect senior civilian experience, combat experience, and expertise in military operational effectiveness. The Panel and designated support personnel shall bring a comprehensive, holistic, and objective approach to study military service by transgender individuals, focusing on military readiness, lethality, and unit cohesion, with due regard for budgetary constraints and consistent with applicable law. The Panel will be chaired by the Under Secretary of Defense for Personnel and Readiness and will report to the Deputy Secretary and the Vice Chairman at least every 30 days and address, at a minimum, the following three areas:

Accessions: The Presidential Memorandum directs DoD to maintain the policy currently in effect, which generally prohibits accession of transgender individuals into military service. The Panel will recommend updated accession policy guidelines to reflect currently accepted medical terminology.

Medical Care: The Presidential Memorandum halts the use of DoD or DHS resources to fund sex-reassignment surgical procedures for military personnel, effective March 23, 2018, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex. The implementation plan will enumerate the specific surgical procedures associated with sex reassignment treatment that shall be prohibited from DoD or DHS resourcing unless necessary to protect the health of the Service member.

Transgender Members Serving in the Armed Forces: The Presidential Memorandum directs that the Department return to the longstanding policy and practice on military service by transgender individuals that was in place prior to June 2016. The Presidential Memorandum also allows the Secretary to determine how to address transgender individuals currently serving in the Armed Forces. The Panel will set forth, in a single policy document, the standards and procedures applicable to military service by transgender persons, with specific attention to addressing transgender persons currently serving. The Panel will develop a universal retention standard that promotes military readiness, lethality, deployability, and unit cohesion.

To support its efforts, the Panel will conduct an independent multi-disciplinary review and study of relevant data and information pertaining to transgender Service members. The study will be planned and executed to inform the Implementation Plan. The independent multi-disciplinary review and study will address aspects of medical care and treatment, personnel management, general policies and practices, and other matters, including the effects of the service of transgender persons on military readiness, lethality, deployability, and unit cohesion.

The Panel may obtain advice from outside experts on an individual basis. The recommendations of the Deputy Secretary and the Vice Chairman will be coordinated with senior civilian officials, the Military Departments, and the Joint Staff.

All DoD Components will cooperate fully in, and will support the Deputy Secretary and the Vice Chairman in their efforts, by making personnel and resources available upon request in support of their efforts.

James N Mattis

cc:
Secretary of Homeland Security

EXHIBIT 5

Thomas P. Dee
SES
703-819-1314
December 14, 2017

MEMORANDUM FOR THE RECORD

Subj: Dissenting Opinion from the Majority Recommendations of the "Military Service by Transgender Individuals - Panel of Experts"

This memorandum records my dissent from the majority opinion of the DoD "Military Service by Transgender Individuals - Panel of Experts" which has recommended the following policy be adopted concerning the military service of transgender individuals:

Redacted

Redacted The recommendations are

Redacted

Redacted are not supported by the data provided to the panel in terms of military effectiveness, lethality, or budget constraints, and are likely not consistent with applicable law.

Recommendation 1.

Redacted

During the course of our panel, neither the transgender service members, the military doctors, nor the civilian doctors suggested that a person serving outside of their birth

gender would necessarily be unable to meet medical or physical standards, nor did any of our briefers suggest that those standards should be loosened or waived to allow transgender service. Redacted

Redacted

DODI 6130.03 governs the physical standards for the appointment, enlistment, or induction of Service personnel. Those standards should apply to everyone regardless of gender identity. The instruction states that individuals under consideration for appointment, enlistment, or induction into the Military Services should be:

1. Free of contagious diseases that probably will endanger the health of other personnel.
2. Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
3. Medically capable of satisfactorily completing required training.
4. Medically adaptable to the military environment without the necessity of geographical area limitations.
5. Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

Enclosure (4) of that instruction provides the specific medical conditions that are disqualifying for service. Redacted The instruction makes no mention of transgenderism or gender dysphoria, but enclosure (4) paragraph 29.r. states that a "current or history of psychosexual conditions including but not limited to transsexualism… tranvestism… and other paraphilias" is disqualifying. The language in that section is no longer consistent with current medical guidelines, the DSM V, which distinguishes gender dysphoria (identity disorder) from psychosexual conditions and paraphilia's (sexual attraction or behaviorial disorder). Redacted

Redacted

Redacted Of note, the FAA allows persons with a history of gender dysphoria to serve as commercial pilots or air traffic controllers after a stability period of five years.

DODI 1304.26, "Qualification Standards for Enlistment, Appointment, and Induction", states that waivers for otherwise disqualifying current or past medical conditions may be considered based on a "whole person" review of the applicant. Redacted

Redacted

Redacted

Redacted No data was presented during the course of the panel to conclude that such separate accommodation would be required Redacted As the total cost of all medical treatment of the entire DoD transgender population over the past few years is $3.3M (exclusive of unit incurred costs) Redacted

Redacted

Recommendation 2.

Redacted

Redacted

Recommendation.

Redacted

//S//
Thomas P. Dee

EXHIBIT 6

Department Of Defense Press Briefing By Pentagon Chief Spokesperson Dana W. White In The Pentagon Briefing Room

Press Operations

Release No:
March 29, 2018

DANA WHITE: Hello, everyone.

Q: Morning.

MS. WHITE: I haven't seen you guys in a -- a week or so. I'm hoping that there's actually spring showing up this weekend. That's my hope.

First, President Trump recently established March 29th as our National Vietnam War Veterans Day. Today is the first anniversary of that special day.

To commemorate our Vietnam War heroes, Deputy Secretary of Defense Patrick Shanahan will host a ceremony this afternoon at the Vietnam Memorial. On behalf of a grateful nation, we want to thank all who served during the Vietnam War, as well as their families, for their service and for their sacrifices.

On the Pentagon's cloud initiative, we are modernizing the department and reforming the way we do business. This is a performance-based, single-award contract. It is a two-year contract with four two-year options. It is an open competition, and the first of many open competitions.

Our goal is to retire legacy systems, streamline our processes and implement a performance-based culture. We want competition, and now we have it.

On the budget, last week, President Trump signed a spending bill appropriating $700 billion for defense. This law, along with the two-year budget agreement, provides the budget certainty we need to implement the National Defense Strategy. We are heartened by the bipartisan support we've

received from Congress. We will use the money to rebuild and restore our military to ensure we remain the most lethal force in the world.

On Monday, Secretary Mattis issued a memorandum to the department reinforcing that every decision we make must focus on lethality and affordability. We are humbled and grateful to the American people for entrusting their hard-earned tax dollars to us. We owe it to them to spend their money wisely.

On transgender, I know you have a lot of questions about this topic, so I want to be up front about what I can address today. We will continue to comply with four court orders assessing transgender applicants for military service, and retaining current transgender service members. Because there is ongoing litigation, and to safeguard the integrity of the court process, I am unable to provide any further details at this time.

On the situation in northern Syria, military operations continue in Syria as we work by, with and through our coalition partners to defeat ISIS and -- and ensure conditions are set to prevent its return.

While the coalition has significantly degraded ISIS, important work remains to guarantee the lasting defeat of these violent extremists. Our commitment to win must outlast the so-called physical caliphate, and the warped ideas that guide the calculated cruelty of ISIS.

This is a group that plots and launches terror attacks globally. They have no regard for anything decent or valuable in life. As long as they exist and bring death and destruction around the world, we will continue to degrade, destroy and ultimately defeat ISIS.

We cannot allow our focus to deviate from the most important task of eliminating ISIS from the region. The ISIS terrorist network is more fragile than it was one year ago, but it is still -- but it still presents a capable and committed threat.

ISIS is taking full advantage of any opportunity to regain momentum. We must not relent on ISIS or permit these terrorists to recover from their battlefield loses.

We are working with our NATO ally Turkey to reassure them that we

understand their security concerns and will appropriately address them as we fight ISIS together. But we must not become distracted and reduce the pressure on ISIS.

The nature of our mission has not changed: The coalition remains committed to the lasting defeat of ISIS.

We will accomplish this by training, advising and assisting our partner forces in Iraq and Syria.

The Syrian Democratic Forces have repeatedly shown they are the most capable force on the ground to defeat ISIS. We will continue to support the SDF as they continue to fight against ISIS.

We will work together to secure and stabilize liberated territory, as our diplomats work to resolve the Syrian conflict through the Geneva Process.

We must quickly resolve our differences in Syria and consolidate our gains to guarantee ISIS does not regroup. We support our diplomats who are working tirelessly to ensure we can finish the ISIS fight.

So with that, I will take your questions.

Lita?

Q: Dana, two things.

One, can you tell us what the topic of the meeting was today with Director Pompeo, Sessions and Senator Graham? Can you just give us an idea of what that was about and if there were additional people in the meeting, who they were?

And then I have a second question.

MS. WHITE: The meeting today was a routine meeting of Cabinet members. The secretary talked about his -- his three priorities, and that's the lethality of the force, it's alliances and partnerships, and the reform that we're bringing. They are -- he is focused on that -- on those issues, so that was the conversation.

Senator Graham is a key member of the Armed Services Committee, and so it's also a part of keeping our Congress -- members of Congress informed of everything we're doing.

But it was a routine conversation.

Q: Okay.

And secondly, I completely understand your reluctance to talk about the transgender lawsuits. I have a question on the actual memo that the Defense Department posted publicly on its website on Friday night.

I think that memo is out there, it's public for everyone to read. But I think there's some confusion about it. And I think the department owes the service members and the public at least some clarity on what the actual document says and what its intent was. Whether or not it -- that has an impact on the lawsuit completely aside, just that actual document itself. Because that was -- it was written and signed by the secretary of defense, and that appears to be the policy that the White House then endorsed.

So my question is -- I just want to make sure I have this clear -- the policy said that transgender troops who have a history of gender dysphoria are disqualified, except under certain circumstances. There were exceptions that could be done.

But it also said that transgender troops who require or have undergone transition are disqualified, and there were no similar exceptions. I want to make sure that I understand correctly that, under the document you posted -- that transgender troops who have actually undergone transition would no longer be allowed to serve, so would be thrown out. Is that an accurate interpretation of what you posted?

MS. WHITE: I'm limited in my ability to talk about it. One, we have to remember that what was posted was a recommendation. The department remains under four court orders, so we continue to assess transgender individuals, as well as retain transgender service members.

But, beyond that, I have to respect the integrity of the litigation. I'd have to refer you to the Department of Justice. They are the lead in this. The documents are there. We made them public as soon as the announcements

were made, so.

Q: But don't you think it's the Pentagon's responsibility to at least explain the document itself -- I mean, just to make clear what the document says?

MS. WHITE: Much of that will be explained through litigation, and, as the Department of Justice is the lead, I have to respect the -- the current process. But we remain under those four court orders and will continue to comply.

Q: Right, I'm not arguing with that. I'm just -- I'm just saying, the document -- is that not a Defense Department document -- right? That is the Defense Department's policy recommendation,

MS. WHITE: It is the -- it is the -- it is the secretary's recommendation that was posted, yes.

Q: Right. And the White House then endorsed it, saying, "We accept the Defense Department's recommendation." So that is the Defense Department's policy?

MS. WHITE: Right. We are under a court order.

Q: No, I understand that. But that was -- that is the department's recommended policy.

MS. WHITE: What was posted was the recommendation. We remain -- the Department of Defense remains under those four court orders. There is current litigation, and until any of that -- any and all of that is resolved, we can't -- I can't comment further.

Q: Okay.

MS. WHITE: I understand, but there is a process that's going on.

Q: Can I follow up on that, actually?

MS. WHITE: Sure.

Q: Because, as reporters, we got -- we all got this -- late Friday night, we got the memo, and we're trying to report accurately on it, and there is some

confusion about the status of currently serving transgender under the -- transgender individuals -- under this new policy that Secretary Mattis signed. His name -- he wrote it. His name is on it.

So again, like Lita, I understand that this is under litigation, but, for our reporting purposes, can some -- can you just explain to us -- currently serving individuals who have undergone reassignment surgery or are in the process of it -- it -- does this policy find that they are eligible to continue to serve, or not?

MS. WHITE: Again...

Q: It doesn't have anything to do with the court. I really understand, and I understand the integrity of the process. But, if this is something that's been presented to the court, why is it that we have to have the court be the -- and the Department of Justice be the ones who explain the -- your policy? The -- do you understand the disconnect here, that...

MS. WHITE: It's a recommendation. The Department of Justice is leading this. They will explain, because there is a court -- this is pending litigation. And, as long as it's pending litigation, there is a very limited amount that we can talk about. We have -- as the secretary said earlier this week, we have to respect the integrity of the process.

The documents are there. They are free for you to read. We put them up as soon as we -- as we could. There were multiple filings that were done. And this is pending litigation.

(CROSSTALK)

MS. WHITE: Tom?

(CROSSTALK)

MS. WHITE: Tom?

(CROSSTALK)

MS. WHITE: Tom?

Q: (Off mic) then why not explain that?

Q: On the same -- on the same subject, I think the documents say there's some -- fewer than a thousand transgenders in the military across the board. Can we get a breakdown of those numbers by service, and how many are in combat arms, how many in support?

You must have some sort of a sense of -- at least which service we're talking about here. Can we get that information?

It has nothing to do with a court case or anything. It should be readily available, I think.

MS. WHITE: I will be happy to talk to OGC about it. But you are dealing with, also, privacy issues, so...

Q: I'm not asking for names, I'm just asking for what the -- the services they're in. And are they in combat arms, they in support, so forth?

MS. WHITE: I'll be happy to take it.

Lalit.

Q: Thank you -- (inaudible).

India is planning to buy S-400 air defense system from Russia. Would CAATSA legislation kick-in to it if India goes ahead with this purchase from -- (inaudible) -- from Russia?

MS. WHITE: Say the second part? What are the implications?

Q: The CAATSA legislation, which is Countering America's Adversaries Through Sanctions Act, prevents American allies to buy certain defense equipment from Russia. And if they go ahead to buy it, do sanctions kick-in (inaudible)?

India being an important partner for U.S. and also for Russia. To India, you know, buys around 60 percent of its equipment from Russia because of its historic relationship with them. Now India is planning to buy S-400 air defense system from Russia. So my questions is, will this legislation kick-in (inaudible) and U.S. will be imposing sanctions on India?

MS. WHITE: I can't comment on pending legislation. But what I can say is that, ultimately, those decisions are sovereign decisions, and so those are decisions that India has to make for itself.

Q: (Inaudible)?

MS. WHITE: Hold on one second.

Ryan?

Q: Thank you, ma'am.

To -- on the border wall, there's a lot of reports that President Trump is looking at having the Department of Defense fund the border wall and re-appropriating funding from the omnibus, potentially.

Is there any effort going on inside this building to look at how that might be done; looking at funding and reauthorization and -- or using National Guard forces? Is there any kind of effort going on the border wall?

And then I have a small, separate question.

MS. WHITE: What I can tell you is that the secretary has talked to the president about it, but I don't have any specifics with respect to any -- any -- any more details than they -- they have spoken about it.

Go ahead, Ryan. Go...

Q: What… about the money being used? To be clear on that -- he's talk to him about using Pentagon funds for the wall? Is that what you asked?

MS. WHITE: They -- they have talked about the proposal, potentially.

Remember, securing Americans and securing the nation is paramount -- of paramount importance to the secretary. They have talked about it, but I don't have any more details with respect to any specifics.

(CROSSTALK)

Q: Can you talk -- can you talk about the purpose of the meeting this afternoon between the secretary and Amb. Bolton?

MS. WHITE: So, this will be the first time that they've met. But it's a very routine meeting, just to -- to start to get to know each other. As the secretary said earlier this week, he looks forward to a very productive partnership.

Q: A follow-up on the wall?

MS. WHITE: (Inaudible) -- go ahead.

Q: Thank you.

You know, over the last few years, and especially as Secretary Mattis took office, really emphasized the state of readiness of U.S. forces and how much money is needed to rebuild the forces, rebuild squadrons. If this wall costs $25 billion, wouldn't that significantly harm this department's ability to buy the ships, to buy the aircraft that it needs to get back to the strength it needs to be?

MS. WHITE: I think -- I think that's a bridge too far, because we don't have those details. And, again, it's -- it's been an initial conversation so I don't have any more details. But if I get more details about a way forward, I will certainly share them.

Q: (inaudible) -- Secretary Mattis pressed the need to keep a focus on lethality, which has been his primary focus the entire time.

MS. WHITE: The -- the president and the secretary, there's no daylight between them with respect to ensuring that this military stays most lethal in the world. That is a -- there is no disagreement with them between -- on that issue.

Idris?

Q: Just going back to transgender very quickly, in the memo, the secretary says the RAND study has significant shortcomings, and then refers to the panel of experts that provided the recommendations.

Could -- could you tell us who is on the panel of experts?

MS. WHITE: Again, I don't have that information. And I -- and I know it's been a request, and we are working on what we can do.

But again, the documents are there -- the supporting documents are there. They stand for themselves.

I understand there are questions, but, again, I have to respect that -- the fact that this is pending litigation.

Q: Is the secretary proud of the recommendations they made?

Because generally if you put something out at 9:30 on a Friday, the impression is that it's being put out there because, you know, it's being hidden or something. And it was not easy to find the memo on -- on the website, either.

I mean, is he proud of the recommendations he's made to the president?

MS. WHITE: The secretary was asked for his -- his thoughts and he provided his recommendation.

The way that this was done, is it was a coordinated effort with the White House as well as the Department of Justice. And because there were multiple filings done in different time zones, it -- it drove the timing of the release.

But as soon as it was done, we provided that information to ensure that there was transparency, that you could read it and could see what his -- not just the memo, but also the supporting document behind it.

So that is his recommendation. And it -- and that -- and that is what it is.

We remain under the four court orders, and therefore we're going to continue to comply and assess transgender individuals as well as retain currently serving transgender service members.

Q: You're not saying that the -- that the names of the people on the panel have an impact on the lawsuit, are you?

MS. WHITE: I'm saying that the documents there have been submitted and that is -- that is what we have submitted.

With respect to the names, I would have to defer and talk to Justice as well as OGC.

Yes?

Q: Can I follow up on that, please?

MS. WHITE: Sure, Nancy.

Q: In the memo -- as Lita -- (inaudible) -- pointed out, there's some ambiguity about what exactly it means in there. Some who -- in the military who -- who might be male who identify as female or vice versa, who say that because of that ambiguity, that they are taking it as a don't-ask, don't-tell sort of approach; that if they identify one way or the other, that because of the ambiguity in the policy, it is best that they do not say what -- what gender they identify with.

Is that an accurate conclusion that one should draw from this memo if you're a currently serving member of the military who may identify in a different sex?

MS. WHITE: What one can assume is that right now the Department of Defense is retaining transgender service members, because we are under four court orders. That is what you can assume.

Beyond that, this is a -- this is pending litigation.

Q: Right, but what I guess I'm asking is in an organization of 2 million personnel, clear personnel policies is critical. And I -- and I -- I'm just trying to understand it.

If you're a transgender service member, if you're a male who identifies as female or vice versa, going forward, until this is settled legally, that you should not reveal what gender you identify with?

MS. WHITE: That is up to an individual. What I can tell you...

Q: But I'm asking what the personnel policy is for this department.

MS. WHITE: The personnel policy of this department is that we continue to allow and assess and retain transgender individuals. That is the current -- that is the state in which we are -- four court orders.

Q: And if I were to come out and identify as a different gender, would that threaten my ability to serve right now in the U.S. military?

MS. WHITE: I'm not going to deal with hypotheticals.

Way in the back.

Q: Okay, going back to the transgender story, what -- I don't understand why, if it's so important the -- the litigation issue, why hasn't your department waited until litigations are over?

Has there has been any kind of pressure from the White House? Why not wait until everything is clear, until the courts have made a decision whether it's constitutional or not? And I have a second question on the budget, but...

MS. WHITE: Well, because, one, there was a memo. The -- the president requested the secretary provide a recommendation, and that was very transparent.

And so, now, we are in this process, and we're going to see it through. We've provided the documents. We've provided the recommendation, and we -- we remain under the court orders.

Q: Yeah, but what's the sense of providing any recommendation if the final decision is going to depend on the courts anyway? I mean, if -- if it's unconstitutional, which could happen, your recommendation would make it -- no sense anyway.

Maybe it would have been better to find out how -- which is exactly the problem before telling the White House -- the White House, sorry -- how to deal with it.

MS. WHITE: This is a process, and -- and, more on the process, I would have to refer you to the Department of Justice. This is current litigation, and this is where we are.

Lucas.

Q: My second question on the -- on the budget, which is really the border wall -- you were saying that Secretary Mattis is really focused on defending the

Americans. But my understanding is that American security in U.S. soil -- it's not -- it has nothing to do with the Department of Defense, or it has more to do with the Department of Homeland Security.

So why ask the Department of Defense? Because the idea that, if -- that people outside this whole business are getting is that Trump -- the president, sorry -- (inaudible) for you to have an increase of your funds, but then -- so he can use it for what he wants, which is not exactly the military.

MS. WHITE: I think it's important to understand that the president and the secretary talk about a variety of subjects. This was one of them. And I don't have any more details for you.

Tom.

(CROSSTALK)

MS. WHITE: Yeah, Tom. Tom.

Q: The conversation that you just referred to, and earlier -- and I realize they have a lot of conversations. But when did they talk about this concept that you brought up, about the -- the money from the defense budget for the wall?

Was it before the president sort of tweeted about it, and made, publicly, his musings on this thought? Or was it after the president did that? And I have a follow-up on another topic.

MS. WHITE: I don't know about the exact timing. Again, the president and the secretary talk frequently. But I -- I can confirm that they have spoken about it. But I don't have any other details, so...

Q: To follow on this transgender thing. What I -- I want to get clear on one thing, please. When and if there's court action that is -- involves the Justice Department and DOD, will it be a Justice Department individual who will then explain the DOD memo that we're referring to here and what it means?

In other words, if there are questions that (inaudible), as raised by some of my colleagues here, will it be a Justice Department person who is explaining that?

MS. WHITE: Yes. So it will be Justice in the lead.

Lucas.

Q: Dana, does the president's...

MS. WHITE: Thank you.

Q: ... pick to be the next VA secretary have to leave the Navy before assuming the job?

MS. WHITE: So this happened yesterday, and so I don't have any -- any details with respect to that. But when we have some more details, I'm certain -- I'll certainly share.

But, again, it -- it happened yesterday.

Q: Does Secretary Mattis have confidence that Rear Adm. Jackson can do the job successfully?

MS. WHITE: I -- we have confidence in the secretary -- in the president's pick. I'm not -- I don't know how familiar the secretary is with the doctor. But he has -- you know, it's the president's pick, and it's for the president to determine who serves in his cabinet.

Q: Was the secretary surprised by the name?

MS. WHITE: The secretary is not surprised by much. So, no, he was not surprised. And he was fully supportive of having Under Secretary Wilkie serve in the interim.

STAFF: Ma'am, we have time for a few more questions.

Q: (Off mic)

MS. WHITE: How about Korea? Go ahead.

(CROSSTALK)

Q: (inaudible) -- I like you.

(Laughter.)

Well, on the exercise of the -- with -- withdrawing U.S. Forces-Korea family members and the Americans in South Korea to the United States, if you have anything on that. Are they going to evacuate U.S. citizens from Korea?

MS. WHITE: I don't have any information on that.

We stay very vigilant. As the secretary had said earlier, as these talks go on, we want the people who are involved in those talks to lead them. But we remain cautiously optimistic about developments.

Tony.

Q: You started off reading a memo that the secretary put out the other day about stewardship of tax dollars. What prompted the memo? Is he concerned that potential overspending may occur on desks and travel and odds and ends that have occurred at HUD and EPA and other places, and he wants to nip that kind of thinking in the bud?

MS. WHITE: What prompted it is the passage. You know, it -- it got overwhelming bipartisan support. And -- and therefore, we're grateful for the increase. I mean, it's -- it's $700 billion, and it's ($)716(billion in FY 2019 budget request). So we're grateful for the increase.

And he knows -- and he wants to ensure that this department is focused on meeting our performance, making sure the warfighter has what they need. He wants us to have budget discipline. He mentions that.

It is a call to action, that we're all responsible for this money. This has been entrusted to us, and it's our responsibility to ensure that we maximize every dollar.

Q: Is he going to take any additional steps, like maybe greater oversight of some key weapons programs and service contracts, where he will put his imprint on a potential contract that may or may not seem overspending?

MS. WHITE: Well, I will tell you that the secretary and the deputy talk frequently with the service -- service secretaries about how are we going to ensure performance. We -- he is -- we are instilling a culture of performance.

I think the biggest change you see -- will see is the fact that you do have, now, two unders, one with Ellen Lord -- with Secretary Lord -- dealing with sustainment, and you have Mike Griffin dealing in future -- in research and engineering. That's a key point, because then we have greater accountability for those capabilities. So now you have two individuals who that is their sole focus.

So we are infusing accountability. We are infusing responsibility. So that was the purpose and the reason, and what prompted his desire to put out that memo.

(CROSSTALK)

MS. WHITE: Jeff

Q: Yeah, I was going to ask about Secretary Wilkie. His portfolio included the close combat lethality portfolio. Who takes that on now?

MS. WHITE: So, Acting Principal Deputy Undersecretary Kurta* will be there in his stead. *[CORRECTION: The department has not yet determined who will serve as Acting Under Secretary of Defense for Personnel and Readiness while Robert Wilkie is acting as Secretary of Veteran's Affairs. Mr. Tony Kurta is currently serving as a Special Assistant to the Under Secretary of Defense for Personnel and Readiness.]

All right.

(CROSSTALK)

Q: ... Mr. Wilkie there today? I mean, did he actually start the job, his...

(CROSSTALK)

MS. WHITE: He will start on Monday.

Q: (inaudible)

MS. WHITE: I haven't gotten to this side.

Corey.

Q: The secretary talks a lot about keeping his recommendations to the president private. Was it the Pentagon's decision or the White House's decision to release that -- the memo of his transgender recommendations?

MS. WHITE: Well, again, as the -- this is in litigation, it be -- when it was filed, it became public. So by all means, we want to provide you, and we did as quickly as we could -- when it was released, we provided it online.

Q: And then on -- do you have any update at all on the Niger investigation? Have the families been notified at this point of anything?

MS. WHITE: I don't have any updates. The secretary is still reviewing it and we will -- we will let you know. First notifications of the family, then to Congress, and then we will let you all know.

Thank you all very, very much.

EXHIBIT 7

Pence secretly drafted Trump's latest transgender military ban

Junk science informed the new order, not military readiness.

ZACK FORD

MAR 25, 2018, 12:51 PM

CREDIT: MARK WILSON/GETTY IMAGES

When President Trump announced a new ban on transgender people serving in the military late Friday, it was somewhat of a surprise — Defense Secretary Jim Mattis had reportedly recommended in February that Trump allow transgender people to serve. It turns out that Vice President Pence and some of the country's most prominent anti-LGBTQ activists had a role in reversing the outcome, which explains why the report explaining the decision is rife with anti-trans junk science.

Slate's Mark Joseph Stern reported Friday night that, according to multiple sources, Pence played "a leading role" in creating the report, along with Ryan T. Anderson of the Heritage Foundation, which has been dubbed "Trump's favorite think tank," and Tony Perkins of the Family Research Council (FRC), an anti-LGBTQ hate group. Both Heritage and FRC praised the report Friday. According to Stern's reporting, it was true that Mattis favored allowing transgender military service, but Pence "effectively overruled" him.

A separate source independently confirmed to ThinkProgress Saturday that Pence was involved, characterizing him as forming his own ad hoc "working group," including Anderson and Perkins, separate from the panel of experts Mattis had assembled. Though it bears Mattis' signature, the report released Friday appears to reflect the findings of Pence's working group and not the committee report that Mattis submitted to Trump last month. Mattis' original document is not currently publicly available, but it was widely reported that Mattis favored an inclusive approach that resembled what had originally been proposed by Defense Secretary Ash Carter under President Obama in 2016.

How exactly Pence overruled Mattis' recommendation over the past month the source did not know. But his working group's influence is apparent. In particular, the report features numerous anti-trans talking points that FRC and other anti-LGBTQ groups have used in various campaigns favoring

discrimination against transgender people. It also attempts to distort the research on transgender health in ways that directly parallel Anderson's recently released book, *When Harry Became Sally: Responding to the Transgender Moment*. Anderson likewise argued in his book against supporting trans people in their gender transitions, and the recommendations in the report rely on a strikingly similar framing.

Asked directly on Saturday whether he was involved in the report, Anderson cheekily responded in a series of tweets that "there's no evidence" he was involved in crafting the report, but he repeatedly refused to directly deny his participation.

"'Privacy" concerns and "unit cohesion"

One of the most obvious biases in the new report is an emphasis on concerns about how transgender people in the military might somehow infringe on the privacy of other soldiers — particularly women. These are the same arguments Perkins, Anderson, and others have made in justifying overturning LGBTQ protections in Houston or defending North Carolina's HB2, a law that mandated discrimination against transgender people.

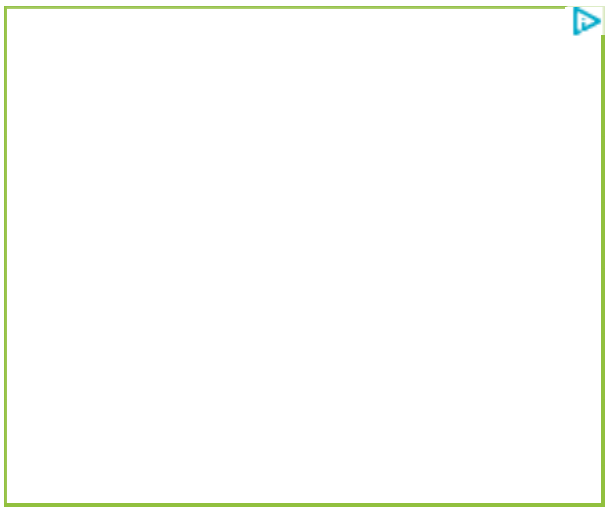
According to the report, transgender people would violate other troops' privacy simply by sharing a space with them — to the detriment of unit cohesion:

> Allowing transgender persons who have not undergone a full sex reassignment [sic], and thus retain at least some of the anatomy of their biological sex, to use the facilities of their identified gender would invade the expectations of privacy that the strict male-female demarcation in berthing, bathroom, and shower facilities is meant to serve.

As examples of these burdens, it notes suggestions from the Carter policy about modifying shower facilities to provide more privacy or adjusting the timing of showers to accommodate service members who express "discomfort" sharing a facility with a transgender person. While these accommodations sound simple, the report instead characterizes them as requiring "significant effort… to solve challenging problems."

Borrowing a related argument opponents of trans equality frequently use (including Anderson in his book), the report also expresses concern that respecting transgender identities would be unfair and even dangerous to other service members when it comes to athletics and training. "Biological females who may be required to compete against such transgender females in training and athletic competition would potentially be disadvantaged," the report claims. This ignores that the NCAA and International Olympic Committee have both established clear standards for allowing transgender people to compete according to their gender identity, recognizing that transitioning mitigates gender-related advantages.

Not so subtly, the report concludes that unit cohesion will deteriorate if the anti-transgender prejudices of other service members are not catered to. "The potential for discord in the unit during the routine execution of daily activities is substantial," it argues. The RAND study that informed the Carter policy had dismissed concerns that lifting the ban would impact cohesion and readiness.



Experts on transgender military service have made clear that lifting the ban will not impact unit cohesion. Three former armed forces secretaries even testified in one of the lawsuits challenging the ban that it is unjustified.

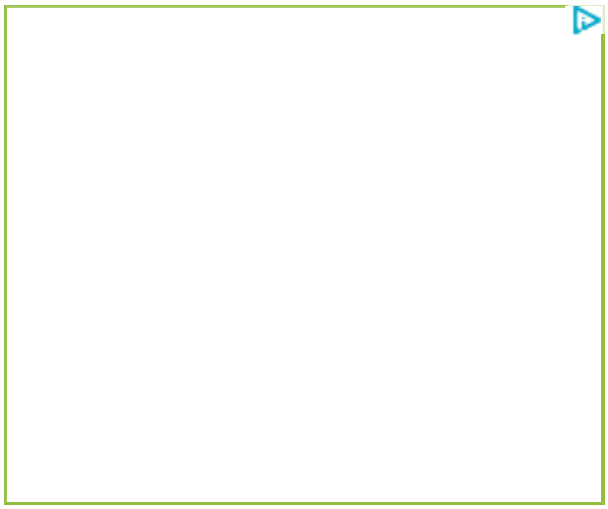
Moreover, "unit cohesion" is the same hollow argument that was previously used to defend "Don't Ask, Don't Tell" (DADT), a law that prohibited lesbian, gay, and bisexual people from serving openly in the military. Such warnings even included near-identical concerns about shared shower use. Following DADT's repeal, a study showed that LGB inclusion had no negative impact on military morale, despite similar warnings.

"Considerable scientific uncertainty"

The report also contorts itself considerably to misrepresent both the experience of transitioning as well as the research about the health and well-being of transgender people. This is where the report most noticeably resembles Anderson's book, as it uses several of the exact same sources and distorts them in the exact same way.

One of the overarching themes in both the report and Anderson's book is that the "quality" of the research showing the benefits of transition is allegedly subpar. It's an attempt to claim that no matter how much research there is showing transition is an effective way to treat gender dysphoria, it simply isn't reliable for reasons like small sample sizes. Anderson has used this approach to justify his position that trans people should be discouraged from transitioning, while the report uses it to justify skepticism about whether people who have transitioned can be trusted to serve capably.

Two examples the new report use are a Centers for Medicare and Medicaid Services (CMS) review from August 2016 and a Hayes Directory review, both of which found that there were actually few studies of the same breadth and rigor that is often used to assess coverage of other medical concerns. But the report relegates to a footnote that CMS still covers transition-related procedures on a case-by-case basis and likewise ignores entirely that, as ThinkProgress has previously pointed out, the Hayes Directory review is actually frequently cited by various health insurance policies to explain why it is the plans *will* cover transition-related procedures. In other words, these reviews of the research tend to support the exact opposite conclusion that the report (and likewise Anderson) draws from them.



The report expresses concern that there have been no "randomized controlled trials" on the effectiveness of hormone replacement therapy (HRT) or gender confirmation surgeries. Because of the nature of transgender identities, however, it would be difficult and likely unethical to take such an approach. That's because gender dysphoria is uniquely a mental health concern treated with physical changes to the body. An individual who was receiving a placebo instead of hormones would easily notice that their body was not undergoing the expected changes. Moreover, given the overwhelming evidence that transgender people do benefit from transitioning, a human subjects review board would likely consider it unethical to deny them medically necessary treatment as part of such a study. The small population of transgender people also limits the size and scope of such studies.

Nowhere does the report even mention that every major medical organization in the U.S. has arrived at a consensus that transgender people should be affirmed in their gender identities and supported in their transitions. The American Medical Association has even explicitly expressed support for lifting the military's ban on transgender service. The report

likewise makes no mention of the widely-used standards of care developed by the World Professional Association of Transgender Health (WPATH), which recognize the benefits of affirmative care.

As has become inevitable in just about every attempt to justify anti-trans discrimination (including Anderson's book), the study also wildly distorts studies about the suicidality of transgender people.

"High rates of suicide ideation, attempts, and completion among people who are transgender are also well documented in the medical literature," the report asserts. It cites an analysis of the National Transgender Discrimination Survey (NTDS), which found that 41 percent of trans people had attempted suicide at some point in their life. It also cites a Swedish study, which the report claims found mortality and psychiatric hospitalization for patients who had undergone sex reassignment surgery as compared to a healthy control group."

What the report downplays is the context of both studies. The NTDS study found significant connections between the high suicide rate and anti-trans discrimination, including factors such as racial stigma, poverty, unemployment, having less education, how easily they were perceived as trans, homelessness, bullying and violence, family rejection, and health care discrimination.

Likewise, the Swedish study did not find significantly higher suicide rates in transgender people who underwent surgery after 1989. Its author, Cecilia Dhejne, explained in an interview that the older group's experience "likely reflects a time when trans health and psychological care was less effective

and social stigma was far worse," emphasizing that transition "won't resolve the effects of crushing social oppression." She has repeatedly rebuked those who use the study to justify rejecting the legitimacy of transgender identities. "I have said many times that the study is not design to evaluate the outcome of medical transition," she said in a Reddit AMA last year. "[I]t does say that people who have transition[ed] are more vulnerable and that we need to improve care."

The report essentially manufactures doubt about the health outcomes of transgender people to justify the very kind of discrimination that is the most significant factor for trans people's negative experiences. This is most apparent when the report attempts to rationalize allowing current transgender service members to continue serving:

> While the Department believes that its commitment to these Service members, including the substantial investment it has made in them, outweigh the risks identified in this report, should its decision to exempt these Service members be used by a court as a basis for invalidating the entire policy, this exemption instead is and should be deemed severable from the rest of the policy.

In other words, if the courts conclude that the policy is blatantly hypocritical by allowing some trans people to continue to serve while banning others from joining, the military will responding by kicking them all out to achieve consistency.

The ex-trans framing

What is perhaps most bizarre about the report is its attempts to show how a transgender person could still serve under the new policy. Essentially, they have to be ex-trans.

The report states that a diagnosis of gender dysphoria is inherently disqualifying for service. This is despite the fact that the American Psychiatric Association does not recognize gender dysphoria as a disorder. It maintains diagnostic criteria for people who are distressed by their gender identity because such a diagnosis is often required for insurance companies to cover transition treatment.

Besides the exemption for current trans troops, the report offers only two ways that someone diagnosed with gender dysphoria could still serve:

> 1. If an individual is trying to join the military but has previously been diagnosed with gender dysphoria, they must show that they have gone three full years without symptoms and be "willing and able to adhere to all standards associated with their biological sex."
> 2. If a current service member is newly diagnosed with gender dysphoria, they may continue serving so long as they do not require gender transition and are "willing and able to adhere to all standards associated with their biological sex.

Given that transitioning is the best proven way to resolve the distress of gender dysphoria, it's unclear who would qualify to serve under these circumstances.

This approach, however, reflects prominent anti-trans views. FRC publicly advocates against affirming transgender people, insisting, "There is no rational or compassionate reason to affirm a distorted psychological self-concept that one's 'gender identity' is different from one's biological sex." Anderson's book likewise focuses on a few exceptional individuals who regretted steps they took to transition their gender, which he argues proves that transition is not helpful or necessary. Anderson, however, did not ask permission from these "detransitioners" to use their narratives and they subsequently objected to being used in a book that rejects transgender people.

The bottom line of the report is that the only good way to be trans in the military is to not be trans. This flies in the face of countless military experts and is easily disproven by the thousands of transgender people already capably serving in the U.S. as well as in 19 other countries, including Australia, the United Kingdom, France, Germany, Spain, Canada, and Israel.

But as the report largely reflects the views of Pence, a longtime opponent of LGBTQ equality, and some of the top anti-LGBTQ activists in the country, it's easy to see how it arrived at such discriminatory conclusions.

#DONALD TRUMP, #FAMILY RESEARCH COUNCIL, #HATE GROUPS, #LGBTQ, #MIKE PENCE, #MLITARY, #POLITICS, #RYAN T. ANDERSON, #TONY PERKINS, #TRANSGENDER

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March for Our Lives crowd tops Trump inauguration, according to organizer esti…

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Kentucky teachers push back against proposed pension cuts days after governor called them 'selfish'

Thinkprogress.org

With their leadership knocked out, young white supremacists face a directionless future

Thinkprogress.org

EXHIBIT 8

washingtonblade.com/2018/03/30/joint-chiefs-not-briefed-trump-went-public-trans-military-ban/

Chris Johnson March 30, 2018

Gen. **Joseph F. Dunford, Jr.** wasn't briefed on the trans military ban before the White House made it public last week. (Photo public domain)

The joint military service chiefs were not briefed on the recommendations by Defense Secretary James Mattis against the transgender military ban or the Trump memo seeking to implement them before the White House went public with them last Friday, according to two sources familiar with the process.

One source said the top uniformed officials at the Pentagon had to download the documents online just like the rest of the public late on March 23 to obtain them for the first time.

Maj. Carla Gleason, a Pentagon spokesperson, wouldn't deny the joint chiefs weren't briefed on the recommendation before it went public, but said their representatives were on the panel of experts that advised Mattis on transgender service before he made his recommendation.

"Recommendations and conversations between the secretary and the president are private, however, each service was represented on the panel of experts," Gleason said.

Gleason said the group of experts on which Mattis relied before making his recommendation

on February 22 to the White House was “a panel of service and joint staff senior leaders.”

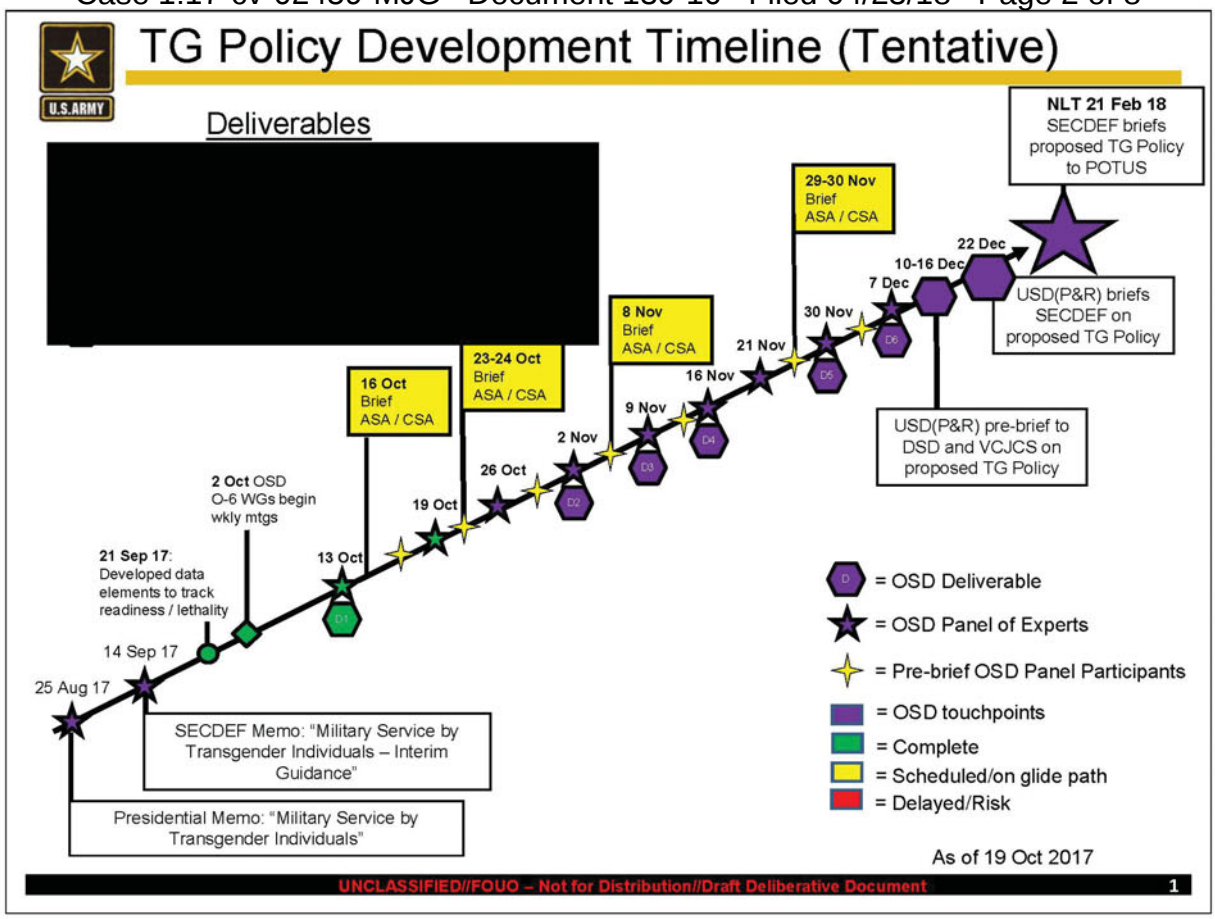
A defense official said the service chiefs may not have had the documents in hand before they went public Friday, but that wasn’t unusual because it was a part of a process in which Mattis was tasked with producing a recommendation and there was no actual policy before the White House issued its memo March 23.

There’s a history of Trump not consulting the joint chiefs on his plan to ban transgender people “in any capacity” from the armed forces, which he announced via Twitter in July. A Buzzfeed report last month on an email exchange immediately after Trump tweeted out his announcement revealed Chair of the Joint Chiefs of Staff Gen. Joseph Dunford called the move “unexpected” and intended to tell Congress he was “not consulted.”

The White House didn’t immediately respond to a request for comment late Friday on why the administration elected not to brief the service chiefs before making the transgender policy public.

Even after the White House made the transgender policy public last week, the Pentagon has insisted it will continue to assess and retain transgender troops in accordance with multiple court orders against Trump’s earlier policy that found banning transgender service members is unconstitutional.

EXHIBIT 9


TG Policy Development Timeline (Tentative)
U.S.ARMY
Deliverables
[redacted]
NLT 21 Feb 18
SECDEF briefs proposed TG Policy to POTUS
29-30 Nov
Brief
ASA / CSA
22 Dec
10-16 Dec
7 Dec
30 Nov
21 Nov
16 Nov
9 Nov
8 Nov
Brief
ASA / CSA
2 Nov
26 Oct
23-24 Oct
Brief
ASA / CSA
19 Oct
16 Oct
Brief
ASA / CSA
13 Oct
2 Oct OSD
O-6 WGs begin
wkly mtgs
21 Sep 17:
Developed data elements to track readiness / lethality
14 Sep 17
25 Aug 17
USD(P&R) briefs SECDEF on proposed TG Policy
USD(P&R) pre-brief to DSD and VCJCS on proposed TG Policy
SECDEF Memo: "Military Service by Transgender Individuals – Interim Guidance"
Presidential Memo: "Military Service by Transgender Individuals"
= OSD Deliverable
= OSD Panel of Experts
= Pre-brief OSD Panel Participants
= OSD touchpoints
= Complete
= Scheduled/on glide path
= Delayed/Risk
As of 19 Oct 2017
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Updates

Panel of Experts (19 Oct 17)

- Next Panel of Experts 26 Oct 17 (Topic: Military Medical Providers)

OSD Evidence on TG Population

- 2016 Workplace and Gender Relations Survey of Active Duty Members
  - Estimate: 8,980 TG AD SMs
  - Designed to evaluate sexual assault/harassment; not gender ID
  - Small sample size data extrapolated across the force
- Assessing Implications of TG Service: RAND
  - Estimated population, impact on readiness
  - Population: 3,960 TG SMs across the force
    - Data extrapolated from 3 surveys of civilian populations
  - Minimal readiness impact
    - Attributed zero non-deployable time to hormone use; experience shows 6 – 12 months non-deployable when initiating hormone therapy

Service Evidence on TG Population

- Service Central Coordination Cells
  - Army: 121
  - Air Force: 175
  - Navy: 240
  - Total: 536
  - Limited to population with medical treatment plan and/or approved gender marker change
- Military Health System:
  - Total number of Soldiers with gender dysphoria dx
  - Army: 405 (89%)
  - Limitation: fails to capture visits for civilian sector: USAR

Personnel Data Collection

Medical Data Collection

- Detailed analysis pending from OEMA
- Profiles (September 2017):
  - Deployable percentage: 72%
  - Temporary profiles: 26%
- Treatment Plans:
  - Approved treatment plan: 90/121 (74%)
  - Psychotherapy as part of treatment plan: 86/90 (96%)
  - Hormones as part of treatment plan: 86/90 (96%)
  - Surgery planned as part of treatment plan: 65/90 (72%)
  - Surgery planned across the population: 65/121 (54%)
- IDES:
  - Enrolled in IDES: 5/121 (4%)

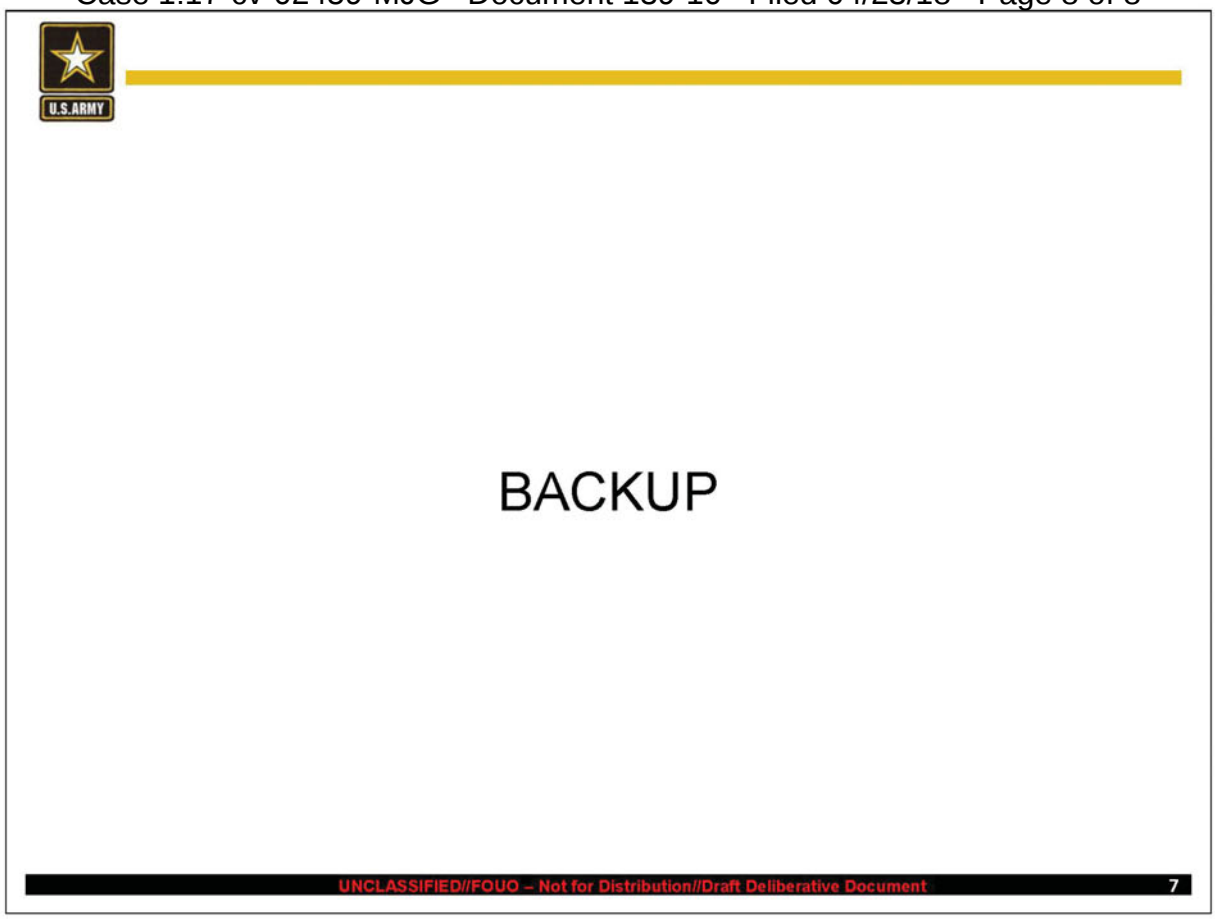
U.S.ARMY
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EXHIBIT 10

PALM CENTER
BLUEPRINTS FOR SOUND PUBLIC POLICY

MARCH 27, 2018

26 Retired General and Flag Officers Oppose Trump Transgender Military Ban

SAN FRANCISCO, CA – Following the American Psychological Association's statement yesterday, expressing alarm over the Trump Administration's "misuse of psychological science to stigmatize transgender Americans and justify limiting their ability to serve in uniform and access medically necessary health care," the Palm Center today released the following statement by 26 retired General and Flag Officers:

> "The Administration's announcement on the treatment of transgender service members is a troubling move backward. Many of us personally experienced the belated removal of 'don't ask, don't tell' and faced firsthand how that mistaken policy set back our force and enabled discrimination against patriotic gay and lesbian Americans. We learned a clear lesson: the singling out of one group of service members for unequal treatment harms military readiness, while inclusion supports it. Under the newly announced policy, most transgender individuals either cannot serve or must serve under a false presumption of unsuitability, despite having already demonstrated that they can and do serve with distinction. They will now serve without the medical care every service member earns, and

with the constant fear of being discharged simply for who they are. We should not return to the days of forcing men and women to hide in the shadows and serve their country without institutional support. This deprives the military of trained and skilled service members, which harms readiness and morale. There is simply no reason to single out brave transgender Americans who can meet military standards and deny them the ability to serve."

Vice Admiral Donald Arthur, USN (Retired)
Vice Admiral Kevin P. Green, USN (Retired)
Lieutenant General Arlen D. Jameson, USAF (Retired)
Lieutenant General Claudia Kennedy, USA (Retired)
Major General Donna Barbisch, USA (Retired)
Major General J. Gary Cooper, USMC (Retired)
Rear Admiral F. Stephen Glass, USN (Retired)
Major General Irv Halter, USAF (Retired)
Rear Admiral Jan Hamby, USN (Retired)
Rear Admiral John Hutson, JAGC, USN (Retired)
Major General Dennis Laich, USA (Retired)
Major General Randy Manner, USA (Retired)
Major General Gale Pollock, CRNA, FACHE, FAAN, USA (Retired)
Major General Peggy Wilmoth, PhD, MSS, RN, FAAN, USA (Retired)
Rear Admiral Dick Young, USN (Retired)
Brigadier General Ricardo Aponte, USAF (Retired)
Rear Admiral Jamie Barnett, USN (Retired)
Brigadier General Julia Cleckley, USA (Retired)

Rear Admiral Jay DeLoach, USN (Retired)
Brigadier General John Douglass, USAF (Retired)
Brigadier General David R. Irvine, USA (Retired)
Brigadier General Carlos E. Martinez, USAF, (Retired)
Brigadier General John M. Schuster USA (Retired)
Rear Admiral Michael E. Smith, USN (Retired)
Brigadier General Paul Gregory Smith, USA (Retired)
Brigadier General Marianne Watson, USA (Retired)

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PRESS CONTACT

EXHIBIT 11

washingtonblade.com/2018/03/29/dod-appears-to-contradict-white-house-on-process-for-trans-military-ban/

Chris Johnson March 29, 2018

The Pentagon has appeared to contradict the White House on drafting the trans military ban. (Public domain photo by Master Sgt. Ken Hammond).

A Defense Department spokesperson appeared Thursday to contradict the White House on the process for drafting the transgender military policy, asserting it was “a coordinated effort” with the White House and Justice Department as opposed to Defense Secretary James Mattis and his working group alone within the Pentagon.

Dana White, a Pentagon spokesperson, made the comments Thursday during aPentagon news briefing in response to a question on timing for the release of the policy late Friday night and whether Mattis was “proud” of his recommendation against transgender military service.

“The secretary was asked for his thoughts, and he provided his recommendation,” White said. “The way that this was done is that it was a coordinated effort with the White House as well as the Department of Justice, and because there were multiple filings done in different time zones, it drove the timing of the release.”

White House Deputy Press Secretary Raj Shah, however, had a different take on the process when asked by the Washington Blade earlier this week whether President Trump, Vice President Mike Pence or anyone at the White House sought to influence the outcome of the recommendations.

“The Department of Defense’s panel of experts was comprised of senior uniformed and civilian leaders who considered the issue based on data and their professional military judgment, without regard to any external factors,” Shah said.

The comments from White lend credence to persistent rumors the policy wasn’t driven by Mattis, but Vice President Mike Pence, who has an anti-LGBT history, even though his office denied he was involved. The comments also suggests U.S. Attorney General Jeff Sessions had a role in developing the policy at the Justice Department.

Neither the White House, nor the Pentagon responded to the Washington Blade’s request to comment on Thursday to clarify the apparent contradiction between the two spokespersons.

White faced intense questioning during the news briefing on the transgender policy from reporters who demanded clarity and pointed out the policy bans transgender service members with limited exceptions, but is unclear and contradictory about those exceptions.

Throughout the briefing, White insisted the U.S. military despite the policy continues to allow, assess and retain transgender service members as a result of multiple court orders that have determined banning transgender service is unconstitutional.

“We will continue to comply with four court orders assessing transgender applicants for military service and retaining current transgender service members,” White said. “Because there is ongoing litigation and to safeguard the integrity of the court process, I am unable to provide any further details at this time.”

That didn’t stop reporters from grilling White. One reporter said he thinks the Pentagon “owes the service members and the public at least some actual clarity about what the actual document says and what its intent was” because it was signed by Mattis.

Pointing out the memo says transgender troops currently in service would be able to stay, but troops who require or undergo transition are disqualified without exception, the reporter asked whether transgender troops who had already transitioned would no longer be able to serve.

White said in response she’s “limited” in her ability to talk about the policy, deferring questions on the policy to the Justice Department, which said called “the lead” on the issue.

“One, we have to remember that what was posted was a recommendation,” White said. “The department remains under four court orders, so we continue to assess transgender individuals as well as retain transgender service members, but beyond that, I have to respect the integrity of the litigation.”

Throughout the briefing, White referred to the transgender military policy as a "recommendation." That supports a recent Buzzfeed report quoting legal experts as saying technically there's no actual policy on transgender service because the memo issued no new guidance even through the Trump administration continues to defend the ban on transgender service in court.

Asked whether what was posted is the Department's recommended policy, White replied: "What was posted was the recommendation. We remain, the Department of Defense remains under those four court orders. There is current litigation, and until any and all of that is resolved, I can't comment further."

In response to a question for another reporter who complained about the challenges in reporting on the confusing memo late Friday night and asked why the Justice Department should be the lead, White replied, "It's a recommendation."

"The Department of Justice is leading this," White said. "They will explain because there is a court — this is pending litigation, and as long as it's pending litigation, there is very limited amounts that we can talk about."

Recalling comments Mattis made earlier in the week in which he said the documents "stand on their own," White said, "We have to respect the integrity of the process. The documents are there. They are free for you to read. We put them up as soon as we could. There are multiple filings that were done and this is pending litigation."

Asked for the individuals who comprised the panel of experts referenced in the Mattis memo, White said she doesn't have the information, but acknowledged multiple reporters are asking about it.

"We are working on what we can do, but again, the documents are there, the supporting documents are there, they stand for themselves," White said. "I understand there are questions, but, again, I have to respect that the fact that is pending litigation."

Another reporter asked why the Trump administration issued the policy now as opposed to waiting until is over. White pointed out the August memo issued by Trump in August called for recommendations from Mattis by February and implementation of a new policy by March 23.

"There was a memo, the secretary provided a recommendation, and that was very transparent," White said. "And so, now we are in this process, and we're going to see it through. We provided the documents, we provided the recommendation and we remain under the court orders."

On whether it was a White House or Pentagon decision to make public the recommendation from Mattis against transgender military service, White said the memo would have been public in any event because it was part of litigation.

"When it was filed, it became public, so by all means, we want to provide you — and we did as quickly as we could — when it was released, we provided it," White said.

Aaron Belkin, director of the San Francisco-based Palm Center, said in a statement after the briefing the Pentagon missed an opportunity to explain the transgender military ban.

“Dana White fielded nine questions about the transgender ban today, and declined to elaborate on the policy,” Belkin said. “What’s more important than whether or not the Pentagon opts to defend the ban is that the ban is based on scientific distortions that the American Psychological Association, American Psychiatric Association and former U.S. surgeons general immediately condemned. The Pentagon is distorting the science, and nothing that spokespersons say or don’t say in the briefing room changes that.”

EXHIBIT 12

Department of Defense

INSTRUCTION

NUMBER 6130.03
April 28, 2010
Incorporating Change 1, September 13, 2011

USD(P&R)

SUBJECT: Medical Standards for Appointment, Enlistment, or Induction in the Military Services

References: See Enclosure 1

1. PURPOSE. This Instruction:

a. Reissues DoD Directive (DoDD) 6130.3 (Reference (a)) as a DoD Instruction (DoDI) in accordance with the authority in DoDD 5124.02 (Reference (b)) to establish policy, assign responsibilities, and prescribe procedures for physical and medical standards for appointment, enlistment, or induction in the Military Services.

b. Establishes medical standards, which, if not met, are grounds for rejection for military service. Other standards may be prescribed for a mobilization for a national emergency.

c. Incorporates and cancels DoDI 6130.4 (Reference (c)).

2. APPLICABILITY. This Instruction applies to:

a. OSD, the Military Departments (including the Coast Guard at all times, including when it is a service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense (hereafter referred to collectively as the "DoD Components").

b. The Reserve Components, which include the Army and the Air National Guards of the United States, in accordance with title 10, United States Code (Reference (d)).

c. The United States Merchant Marine Academy in accordance with section 310.56 of title 46, Code of Federal Regulations (Reference (e)).

3. DEFINITIONS. See Glossary.

4. POLICY. It is DoD policy to:

a. Utilize common physical standards for the appointment, enlistment, or induction of Service personnel and eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services.

b. Precisely define any medical condition that causes a personnel action, such as separation, medical waiver, or assignment limitation, by utilizing the International Classification of Diseases (ICD) (Reference (f)), Current Procedural Terminology (CPT) (Reference (g)), and the Healthcare Common Procedure Coding System (HCPCS) (Reference (h)), and annotate qualification decisions by standard medical terminology, rather than codes. The standards in this Instruction shall be for the acquisition of personnel in the Military Services.

c. Ensure that individuals under consideration for appointment, enlistment, or induction into the Military Services are:

(1) Free of contagious diseases that probably will endanger the health of other personnel.

(2) Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.

(3) Medically capable of satisfactorily completing required training.

(4) Medically adaptable to the military environment without the necessity of geographical area limitations.

(5) Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

5. RESPONSIBILITIES. See Enclosure 2.

6. PROCEDURES. See Enclosure 3 for Medical and Personnel Executive Steering Committee (MEDPERS) information. Procedures and standards for implementation are in Enclosure 4.

7. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Website at http://www.dtic.mil/whs/directives.

8. EFFECTIVE DATE. This Instruction is effective immediately.

Clifford L. Stanley
Under Secretary of Defense for
Personnel and Readiness

Enclosures
1. References
2. Responsibilities
3. Medical and Personnel Executive Steering Committee
4. Medical Standards for Appointment, Enlistment, or Induction

Glossary

TABLE OF CONTENTS

ENCLOSURE 1

REFERENCES

(a) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, or Induction," December 15, 2000 (hereby cancelled)
(b) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(c) DoD Instruction 6130.4, "Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces," January 18, 2005 (hereby cancelled)
(d) Title 10, United States Code
(e) Section 310.56 of title 46, Code of Federal Regulations
(f) International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)[1]
(g) American Medical Association, Current Procedural Terminology (CPT®), Fourth Edition, 2010 Revision, Chicago, IL, 2010[2]
(h) 2010 Healthcare Common Procedure Coding System (HCPCS) Level II Codes from Centers for Medicare and Medicaid Services (CMS)[2]
(i) American National Standards Institute ANSI S3.6-2004, "Specification for Audiometers"[3]
(j) Joint Publication 1-02, "Department of Defense Dictionary of Military and Associated Terms," current edition

[1] Available at http://www.cdc.gov/NCHS/icd/icd9cm.htm.
[2] Available at https://catalog.ama-assn.org/Catalog/cpt/cpt_home.jsp
[3] Available from the American National Standards Institute, 1819 L Street, N.W., Washington, D.C. 20036 or on the Internet at http://www.ansi.org/

ENCLOSURE 2

RESPONSIBILITIES

1. PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (PDUSD(P&R)). The PDUSD(P&R), under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), shall:

a. Ensure that the standards in Enclosure 4 are implemented throughout the U.S. Military Entrance Processing Command.

b. Eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services.

c. Convene the MEDPERS under the joint guidance of the Deputy Under Secretary of Defense for Military Personnel Policy (DUSD(MPP)) and Principal Deputy Assistant Secretary of Defense for Health Affairs (PDASD(HA)). MEDPERS responsibilities are in Enclosure 3.

2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). The ASD(HA), under the authority, direction, and control of the USD(P&R), shall:

a. Review, approve, and issue to the Secretaries of the Military Departments technical modifications to the standards in Enclosure 4.

b. Provide guidance to the DoD Medical Examination Review Board to implement the standards in Enclosure 4.

c. Eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services.

3. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT OF THE COAST GUARD. The Secretaries of the Military Departments and Commandant of the Coast Guard shall:

a. Direct their respective Services to apply and uniformly implement the standards contained in this Instruction.

b. Authorize the waiver of the standards in individual cases for applicable reasons and ensure uniform waiver determinations.

c. Authorize the changes in Service-specific visual standards (particularly for officer accession programs) and establish other standards for special programs. Notification of any

proposed changes in standards shall be provided to the ASD(HA) at least 60 days before implementation.

d. Ensure that accurate ICD codes are assigned to all medical conditions resulting in a personnel action, such as separation, waiver, or assignment limitation, and that such codes are included in all records of such actions.

e. Eliminate inconsistencies and inequities based on race, sex, or examination location in the application of these standards by the Military Services.

ENCLOSURE 3

MEDPERS

1. MEDPERS convenes quarterly under the joint guidance of the DUSD(MPP) and PDASD(HA).

2. MEDPERS shall:

a. Provide policy oversight and guidance to the accession medical and physical standards setting process through the Accession Medical Standards Working Group.

b. Direct research and studies as necessary to produce evidence-based accession standards utilizing the Accession Medical Standards Analysis and Research Activity.

c. Ensure medical and personnel community coordination when formulating policy changes that affect each community and other relevant DoD *and* Department of Homeland Security~~, and Department of Transportation~~ organizations.

ENCLOSURE 4

MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION

1. APPLICABILITY. The medical standards in this enclosure apply to:

a. Applicants for appointment as commissioned or warrant officers in the Active and Reserve Components.

b. Applicants for enlistment in the Military Services. For medical conditions or defects predating original enlistment, these standards apply to enlistees' first 6 months of active duty.

c. Applicants for enlistment in the Reserve Components and federally recognized units or organizations of the National Guard. For medical conditions or defects predating original enlistment, these standards apply during the enlistees' initial period of active duty for training until their return to Reserve or National Guard units.

d. Applicants for reenlistment in Regular and Reserve Components and in federally recognized units or organizations of the National Guard after a period of more than 12 months have elapsed since discharge.

e. Applicants for the Scholarship or Advanced Course Reserve Officer Training Corps (ROTC), and all other Military Services' special officer personnel procurement programs.

f. Cadets and midshipmen at the U.S. Service academies and students enrolled in ROTC scholarship programs applying for retention in their respective programs.

g. Individuals on the Temporary Disability Retired List (TDRL) who have been found fit on reevaluation by the Physical Disability Evaluation System (PDES) and who elect to return to active duty or to active status in the Reserve Components within the time standards prescribed by Service Regulations. These individuals are exempt from this Instruction for the conditions for which they were found fit on reevaluation by the PDES.

h. All individuals being inducted into the Military Services.

2. MEDICAL STANDARDS. Throughout this enclosure, ICD, CPT and HCPCS codes are included with most medical conditions and procedures, usually parenthetically, to aid cross-referencing. Unless otherwise stipulated, the conditions listed in this enclosure are those that do NOT meet the standard by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment, or induction into the Military Services are classified by the general systems described in *sections* 3-~~30~~*31* of this enclosure.

3. HEAD

a. Deformities of the skull, face, or mandible (738.19, 744.9, 754.0) of a degree that shall prevent the individual from the proper wearing of a protective mask or military headgear.

b. Loss, or absence of the bony substance of the skull (756.0 or 738.19) not successfully corrected by reconstructive materials, or leaving any residual defect in excess of 1 square inch (6.45 square centimeters), or the size of a 25-cent piece.

4. EYES

a. Lids

(1) Current symptomatic blepharitis (373.0x).

(2) Current blepharospasm (333.81).

(3) Current dacryocystitis, acute (375.32), or chronic (375.42).

(4) Defect or deformity of the lids or other disorders affecting eyelid function (374.4x, 374.50, 374.85, 374.89, 743.62), complete, or significant ptosis (374.3x, 743.61), sufficient to interfere with vision or impair protection of the eye from exposure.

(5) Current growths or tumors of the eyelid (173.1, 198.2, 216.1, 232.1, 238.8, 239.89), other than small, non-progressive, asymptomatic, benign lesions.

b. Conjunctiva

(1) Current acute or chronic conjunctivitis (372.1x, 077.0). Seasonal allergic conjunctivitis (372.14) DOES meet the standard.

(2) Current pterygium (372.4x) if condition encroaches on the cornea in excess of 3 millimeters, interferes with vision, is progressive, or a history of recurrence after any prior surgical removal (372.45).

c. Cornea

(1) Corneal dystrophy or degeneration of any type (371.x), including but not limited to keratoconus (371.6x) of any degree.

(2) History of any incisional corneal surgery including, but not limited to, partial or full thickness corneal transplant, radial keratotomy (RK), astigmatic keratotomy (AK), or corneal implants (Intacs®)

(3) Corneal refractive surgery performed with an excimer laser, including but not limited to photorefractive keratectomy (PRK) (HCPCS S0810), laser epithelial keratomileusis (LASEK), and laser-assisted in situ keratomileusis (LASIK) (HCPCS S0900) (ICD-9 code for each is P11.7) if any of the following conditions are met:

(a) Pre-surgical refractive error in either eye exceeded a spherical equivalent of +8.00 or -8.00 diopters.

(b) Pre-surgical astigmatism exceeded 3.00 diopters.

(c) For corneal refractive surgery, at least 180 days recovery period has not occurred between last refractive surgery or augmenting procedure and accession medical examination.

(d) There have been complications and/or medications or ophthalmic solutions, or any other therapeutic interventions such as sunglasses, are required.

(e) Post-surgical refraction in each eye is not stable as demonstrated by at least two separate refractions at least 1 month apart, with initial refraction at least 90 days post-procedure, and the most recent of which demonstrates more than +/- 0.50 diopters difference for spherical vision and/or more than +/- 0.50 diopters for cylinder vision.

(4) Current or recurrent keratitis (370.xx)

(5) Documented herpes simplex virus keratitis (054.42, 054.43).

(6) Current corneal neovascularization, unspecified (370.60), or corneal opacification (371.00, 371.03) from any cause that is progressive or reduces vision below the standards prescribed in this Instruction.

(7) Current or history of uveitis or iridocyclitis (364.00-364.3).

d. Retina

(1) Current or history of any abnormality of the retina (361.00-362.89, 363.14-363.22), choroid (363.00-363.9) or vitreous (379.2x).

e. Optic Nerve

(1) Any current or history of optic nerve disease (377.3), including but not limited to optic nerve inflammation (363.05), optic nerve swelling, or optic nerve atrophy (377.12, 377.14).

(2) Any optic nerve anomaly.

f. Lens

(1) Current aphakia (379.31, 743.35), history of lens implant (V45.61, V43.1) (CPT 66982-66986), or current or history of dislocation of a lens (379.32-379.34, 743.37).

(2) Current or history of opacities of the lens (366.xx), including cataract (366.9).

g. Ocular Mobility and Motility

(1) Current or recurrent diplopia (368.2).

(2) Current nystagmus (379.5x) other than physiologic "end-point nystagmus."

(3) Esotropia (378.0x), exotropia (378.1x), and hypertropia (378.31): For entrance into Service academies and officer programs, the individual Military Services may set additional requirements. The Military Services shall determine special administrative criteria for assignment to certain specialties.

h. Miscellaneous Defects and Diseases

(1) Current or history of abnormal visual fields (368.9) due to diseases of the eye or central nervous system (368.4x), or trauma.

(2) Absence of an eye (V43.0, V45.78), clinical anophthalmos, unspecified congenital (743.00) or acquired, or current or history of other disorders of globe (360.xx).

(3) Current unilateral or bilateral exophthalmoses (376.21-376.36).

(4) Current or history of glaucoma (365.xx), ocular hypertension, pre-glaucoma (365.0-365.04), or glaucoma suspect.

(5) Any abnormal pupillary reaction to light (379.4x) or accommodation (367.5x).

(6) Asymmetry of pupil size greater than 2mm.

(7) Current night blindness (264.5, 368.6x).

(8) Current or history of intraocular foreign body (360.50-360.69, 871.x).

(9) Current or history of ocular tumors (190.0, 190.8-190.9, 198.4, 224.0, 224.8-224.9, 234.0, 238.8, 239.89, V10.84).

(10) Current or history of any abnormality of the eye (360) or adnexa (376, 379.9), not specified in subparagraphs 4.h.(1)-(9) of this enclosure, which threatens vision or visual function V41.0-V41.1, V52.2, V59.5).

5. VISION

a. Current distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following (367):

(1) 20/40 in one eye and 20/70 in the other eye (369.75).

(2) 20/30 in one eye and 20/100 in the other eye (369.75).

(3) 20/20 in one eye and 20/400 in the other eye (369.73).

b. Current near visual acuity of any degree that does not correct to 20/40 in the better eye (367.1-367.32).

c. Current refractive error (hyperopia (367.0), myopia (367.1), astigmatism (367.2x)), in excess of -8.00 or +8.00 diopters spherical equivalent or astigmatism in excess of 3.00 diopters.

d. Any condition requiring contact lenses for adequate correction of vision, such as corneal scars and opacities (370.0x) and irregular astigmatism (367.22).

e. Color vision (368.5x) requirements shall be set by the individual Services.

6. EARS

a. Current atresia of the external ear (744.02) or severe microtia (744.23), congenital or acquired stenosis (380.5x), chronic otitis externa (380.15-380.16, 380.23), or severe external ear deformity (380.32, 738.7, 744.01, 744.3) that prevents or interferes with the proper wearing of hearing protection.

b. Current or history of Ménière's Syndrome or other chronic diseases of the vestibular system (386.xx).

c. History of cochlear implant.

d. Current or history of cholesteatoma (385.3x)

e. History of any inner (P20) (CPT 69801-69930) or middle (P19) (CPT 69631-69636, 69676) ear surgery excluding successful tympanoplasty (CPT 69635) performed during the preceding 180 days.

f. Current perforation of the tympanic membrane (384.2x) or history of surgery to correct perforation during the preceding 180 days (P19) (CPT 69433, 69436, 69610, 69631-69646).

g. Chronic Eustachian tube dysfunction as evidenced by retracted tympanic membrane, or recurrent otitis media, or the need for pressure-equalization (PE) tube within the last 3 years.

7. HEARING All hearing defects are coded with ICD-9 code 389.xx.

a. Audiometric hearing levels are measured by audiometers calibrated to the standards in American National Standards Institute (ANSI S3.6-2004) (Reference (i)) and shall be used to test the hearing of all applicants.

b. Current hearing threshold level in either ear greater than that described in subparagraphs 7.b.(1)-(3) of this enclosure does not meet the standard:

(1) Pure tone at 500, 1000, and 2000 cycles per second for each ear of not more than 30 decibels (dB) on the average with no individual level greater than 35 dB at those frequencies.

(2) Pure tone level not more than 45 dB at 3000 cycles per second or 55 dB at 4000 cycles per second for each ear.

(3) There is no standard for 6000 cycles per second.

c. Current or history of hearing aid use (V53.2).

8 NOSE, SINUSES, MOUTH, AND LARYNX

a. Current cleft lip or palate defects (749.xx) not satisfactorily repaired by surgery or that interfere with use or wear of military equipment, or that prevent drinking from a straw.

b. Current ulceration of oral mucosa, including tongue (528.6), excluding apthous ulcers.

c. Current chronic conditions of larynx including vocal cord paralysis (478.3x) or history of laryngeal papillomatosis.

d. History of non-benign polyps, (478.4) chronic hoarseness (78.49), chronic laryngitis (476.0) or spasmodic dysphonia.

e. Current anosmia or parosmia (781.1).

f. History of recurrent epistaxis with more than one episode per week of bright red blood from the nose occurring over a 3-month period (784.7) within the last 3 years.

g. Current nasal polyp or history of nasal polyps (471.x), unless more than 12 months have elapsed since nasal polypectomy (CPT 30110, 30115, 31237-31240) and/or sinus surgery, and asymptomatic.

h. Current perforation of nasal septum (478.1, 478.19, 748.1).

i. Current chronic sinusitis (473) as evidenced by chronic purulent discharge, symptoms requiring frequent medical attention, or computed tomography (CT) scan.

j. Current or history of deformities, or conditions or anomalies of the upper alimentary tract (750.9), mouth (750.26), tongue (750.1x), palate, throat, pharynx, larynx (748.3), and nose (748.1), that interfere with chewing (V41.6), swallowing, speech, or breathing.

9 DENTAL

a. Current diseases or pathology of the jaws or associated tissues that prevent normal functioning. Those diseases or conditions include but are not limited to temporomandibular disorders (524.6x) and/or myofascial pain (784.0). A minimum of 6 months healing time must elapse for any individuals completing surgical treatment of any maxillofacial pathology lesions.

b. Current severe malocclusion (524.00-524.29, 524.4), which interferes with normal chewing or requires immediate and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement.

c. Eight or more grossly (visually) cavitated and/or carious teeth (521.0x). Applicants who are edentulous must have functioning dentures. Lack of a serviceable prosthesis that prevents adequate biting and chewing of a normal diet. Individuals undergoing endodontic care are acceptable for entry into the Delayed Entry Program (DEP) only if a civilian or military dentist or endodontist provides documentation that active endodontic treatment shall be completed prior to being sworn to active duty.

d. Current orthodontic appliances (mounted or removable, i.e., Invisalign®) for continued active treatment (V53.4). Permanent or removable retainers are permissible. Individuals undergoing active orthodontic care are acceptable for accession (including DEP) only if a civilian or military orthodontist provides documentation that active orthodontic treatment shall be completed prior to being sworn into active duty. Entrance to active duty will not occur until all orthodontic treatment is documented to be completed.

10 NECK

a. Current symptomatic cervical ribs (756.2).

b. Current congenital cyst(s) (744.4x) of branchial cleft origin or those developing from the remnants of the thyroglossal duct (759.2).

c. Current contraction (723.5, 754.1)) of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent it interferes with the proper wearing of a uniform or military equipment, or is so disfiguring as to interfere with or prevent satisfactory performance of military duty.

11. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM

a. Current abnormal elevation of the diaphragm (either side) (756.6). Any nonspecific abnormal findings on radiological and other examination of body structure, such as lung field (793.1) or other thoracic or abdominal organ (793.2).

b. Current abscess of the lung (513.0) or mediastinum (513.1).

c. Current or history of recurrent acute infectious processes of the lung, including but not limited to viral pneumonia (480.x), pneumococcal pneumonia (481), bacterial pneumonia (482.xx), pneumonia due to other specified organism (483.x), pneumonia infectious disease classified elsewhere (484.x), bronchopneumonia (organism unspecified) (485), and pneumonia (organism unspecified) (486).

d. Airway hyper responsiveness including asthma (493.xx), reactive airway disease, exercise-induced bronchospasm (519.11) or asthmatic bronchitis (493.90), reliably diagnosed and symptomatic after the 13th birthday.

(1) Reliable diagnostic criteria may include any of the following elements: substantiated history of cough, wheeze, chest tightness, and/or dyspnea which persists or recurs over a prolonged period of time, generally more than 12 months.

(2) Individuals *DO* MEET the standard if within the past 3 years they meet ALL of the criteria in subparagraphs 11.d.(2)(a)-(d).

(a) No use of controller or rescue medications (including, but not limited to inhaled corticosteroids, leukotriene receptor antagonists, or short-acting beta agonists).

(b) No exacerbations requiring acute medical treatment.

(c) No use of oral steroids.

(d) A current normal spirometry (within the past 90 days), performed in accordance with American Thoracic Society (ATS) guidelines and as defined by current National Heart, Lung, and Blood Institute (NHLBI) standards.

e. Chronic obstructive pulmonary disease (491).

(1) Current or history of bullous or generalized pulmonary emphysema (492).

(2) Current bronchitis (490), acute or chronic symptoms over 3 months occurring at least twice a year (491).

f. Current or history of bronchiectasis (494). Bronchiectasis during the first year of life is not disqualifying if there are no residual or sequelae.

g. Current or history of bronchopleural fistula (510.0), unless resolved with no sequelae.

h. Current chest wall malformation (754.89), including but not limited to pectus excavatum (754.81) or pectus carinatum (754.82), if these conditions interfere with vigorous physical exertion.

i. History of empyema (510.9).

j. Pulmonary fibrosis (515).

k. Current foreign body in lung (934.8, 934.9), trachea (934.0), or bronchus (934.1).

l. History of thoracic surgery (32-33), (CPT 32035-32999, 33010-33999, 43020-43499) including open and endoscopic procedures.

m. Current or history of pleurisy with effusion (511.9) within the previous 2 years.

n. Current or history of pneumothorax (512) occurring during the year preceding examination if due to trauma (860) or surgery, or occurring during the 2 years preceding examination from spontaneous (512.8) origin.

o. Recurrent spontaneous pneumothorax (512.8).

p. History of chest wall surgery (34-34.9), including breast (85-85.9), during the preceding 6 months, or with persistent functional limitations.

12. HEART

a. History of valvular repair or replacement (CPT 33400-33478).

(1) Current or history of the following valvular conditions as defined by the current American College of Cardiology and American Heart Association guidelines:

(a) Severe pulmonic regurgitation.

(b) Severe tricuspid regurgitation.

(c) Moderate pulmonic regurgitation unless documented mean pulmonary artery pressure is less than 25 mmHg.

(d) Moderate tricuspid regurgitation unless documented mean pulmonary artery pressure is less than 25 mmHg.

(e) Moderate or severe mitral regurgitation.

(f) Mild, moderate, or severe aortic regurgitation.

(2) The following are considered normal variants that meet accession standards:

(a) Trace or mild pulmonic regurgitation.

(b) Trace or mild tricuspid regurgitation.

(c) Trace or mild mitral regurgitation in the absence of mitral valve prolapse.

(d) Trace aortic insufficiency.

b. Mitral valve prolapsed (396.3) with normal exercise tolerance not requiring medical therapy DOES meet the standard.

c. Bicuspid aortic valve (746.4), in the absence of stenosis or regurgitation as in *sub*paragraph*s* 12.a.*(1)(a)-(f)*, DOES meet the standard.

d. All valvular stenosis (396).

e. Current or history of atherosclerotic coronary artery disease (410).

f. Current or history of pacemaker or defibrillator implantation (CPT 3320-33249).

g. History of supraventricular tachycardia (427.0).

(1) History of recurrent atrial fibrillation (427.31) or flutter (427.32).

(2) Supraventricular tachycardia (427.0) associated with an identifiable reversible cause and no recurrence during the preceding 2 years while off all medications DOES meet the standard.

(3) Those with identified atrioventricular nodal reentrant tachycardia or atrioventricular reentrant tachycardia (such as Wolff-Parkinson-White (WPW) syndrome) (426.7) who have undergone successful ablative therapy with no recurrence of symptoms after 3 months and with documentation of normal electrocardiograph (ECG) meet the standard.

h. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or psychological impairment.

i. Abnormal ECG patterns (794.31):

(1) Long QT (426.82).

(2) Brugada pattern.

(3) WPW syndrome (426.7) pattern unless associated with low risk accessory pathway by appropriate diagnostic testing.

j. Current or history of ventricular arrhythmias (427.1) including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions. Occasional asymptomatic unifocal premature ventricular contractions meet the standard.

k. Current or history of conduction disorders, including but not limited to disorders of sinus arrest, asystole, Mobitz type II second-degree atrioventricular (AV) block (426.12), and third-degree AV block (426.0).

l. In the absence of cardiovascular symptoms, the following meet the standard:

(1) Sinus arrhythmia.

(2) First degree AV block (426.11).

(3) Left axis deviation of less than -45 degrees.

(4) Early repolarization.

(5) Incomplete right bundle branch block.

(6) Wandering atrial pacemaker (427.89) or ectopic atrial rhythm (427.89).

(7) Sinus bradycardia (427.81).

(8) Mobitz type I second-degree AV block (426.13).

m. Current or history of conduction disturbances such as left anterior hemiblock (426.2), right or left bundle branch block (426.4) do not meet the standard unless asymptomatic with a normal echocardiogram.

n. Current or history of cardiomyopathy (425), cardiomegaly, hypertrophy (defined as septal wall thickness of 15 mm or greater), dilation (429.3), or congestive heart failure (428).

o. History of myocarditis (422) or pericarditis (420) unless the individual is free of all cardiac symptoms, does not require medical therapy, and has normal echocardiography for at least 1 year.

p. Current persistent tachycardia (785.0) (as evidenced by average heart rate of 100 beats per minute or greater over a 24-hour period of continuous monitoring).

q. Current or history of congenital anomalies of heart and great vessels (746). The following conditions meet the standard with an otherwise normal current (within 6 months) echocardiogram.

(1) Dextrocardia (746.87) with situs inversus (759.3) without any other anomalies.

(2) Ligated or occluded patent ductus arteriosus (747.0).

(3) Corrected atrial septal defect (745.9) or patent foramen ovale (745.5) without residua.

(4) Corrected ventricular septal defect (745.4) without residua.

r. History of recurrent syncope and or presyncope (780.2), including black out, fainting, loss or alteration of level of consciousness (excludes vasovagal reactions with identified trigger such as venipuncture) unless there has been no recurrence during the preceding 2 years while off all medication.

s. Unexplained ongoing or recurring cardiopulmonary symptoms (to include but not limited to syncope, presyncope, chest pain, palpitations, and dyspnea on exertion) that impairs a physically active lifestyle.

t. History of rheumatic fever (390).

13. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM

a. Esophageal Disease

(1) Current or history of esophageal disease (530.0-530-9), including but not limited to ulceration, varices, fistula, or achalasia.

(2) Gastro-Esophageal Reflux Disease (GERD) (530.81), with complications~~, including stricture, or maintenance on acid suppression medication, other dysmotility disorders; or chronic or recurrent esophagitis (530.1)~~.

(a) Stricture or B-ring.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagitis.

(e) Extraesophageal complications; reactive airway disease; recurrent sinusitis or dental complications.

~~(3) Current or history of reactive airway disease associated with GERD (530.81).~~

(~~43~~) History of surgical correction *(fundoplication or dilation)* for GERD within 6 months ~~(P42 esophageal correction, P43 stomach correction, and P45 intestinal correction) (CPT 43257)~~*(45.89)*.

(~~54~~) Current or history of dysmotility disorders ~~and chronic or recurrent esophagitis (530).~~*, to include diffuse esophageal spasm, nutcracker esophagus, non-specific motility disorder, and achalasia.*

(5) Eosinophilic esophagitis.

(6) Other esophageal strictures, for example lye or other caustic ingestion.

b. Stomach and Duodenum

(1) Current ~~gastritis, chronic or severe (535), or non-ulcerative dyspepsia that requires maintenance medication~~ *dyspepsia requiring medication; or history of dyspepsia lasting 3 or more consecutive months and requiring medication within the preceding 12 months.*

(2) ~~Current or history of ulcer of the stomach or duodenum confirmed by X-ray or endoscopy (533).~~ *Gastric or duodenal ulcers:*

(a) Current ulcer or history of treated ulcer within the last 3 months.

(b) Recurrent or complicated by bleeding, obstruction, or perforation within preceding 5 years confirmed by endoscopy.

(3) History of surgery for peptic ulceration or perforation (533.0-599.9).

(4) History of gastroparesis.

(5) History of bariatric surgery of any type (e.g., lap-band or gastric bypass surgery for weight loss).

(6) History of gastric varices.

c. Small and Large Intestine

(1) Current or history of inflammatory bowel disease, including but not limited to ~~unspecified~~ *indeterminate* (558.9), ~~regional enteritis or~~ Crohn's disease (555), ulcerative colitis (556), or ulcerative proctitis (556.2).

(2) Current infectious colitis not otherwise specified (009.1).

(~~23~~) Current or history of intestinal malabsorption syndromes (579.9), including but not limited to *celiac sprue, pancreatic insufficiency,* post-surgical and idiopathic (579). Lactase

deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with normal function.

(~~3~~*4*) Current or history of gastrointestinal functional and motility disorders within the past 2 years, including but not limited to pseudo-obstruction, megacolon, history of volvulus, or chronic constipation (564.0) and or diarrhea (787.91), regardless of cause, persisting or symptomatic in the past 2 years.

(~~4~~*5*) History of gastrointestinal bleeding (578), including positive occult blood (792.1), if the cause has not been corrected. Meckel's diverticulum (751.0), if surgically corrected more than 6 months prior DOES meet the standard.

(~~5~~*6*) Current or history of irritable bowel syndrome (564.1) of sufficient severity to require frequent intervention *or prescription medication* or to interfere with normal function.

(~~6~~*7*) History of bowel resection (CPT 44202-44203).

(~~7~~*8*) Current or history of symptomatic diverticular disease of the intestine (562).

(9) Personal or family history of familial adenomatous polyposis syndrome or hereditary non-polyposis colon cancer syndrome.

d. Hepatic-Biliary Tract

(1) Current acute or chronic hepatitis, hepatitis carrier state (070), hepatitis in the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function.

(2) Current or history of cirrhosis (571), hepatic cysts (573.8), abscess (572.0), or sequelae of chronic liver disease (571.3).

(3) Current or history of symptomatic cholecystitis (575.10), unless successfully surgically corrected~~, acute or chronic, with or without cholelithiasis (574)~~; postcholecystectomy syndrome; or other disorders of the gallbladder and biliary system (576). Cholecystectomy DOES meet the standard if performed more than 6 months prior to examination and patient remains asymptomatic. ~~Fiberoptic~~ *Endoscopic* procedure to correct ~~sphincter dysfunction or cholelithiasis~~ *choledocholithiasis*, if performed more than 6 months prior to examination and patient remains asymptomatic, MAY meet the standard.

(4) History of sphincter of Oddi dysfunction.

(5) Choledochocyst.

(6) Primary biliary cirrhosis or primary sclerosing cholangitis.

(~~4~~*7*) Current or history of pancreatitis, acute (577.0) or chronic (577.1).

(8) Pancreatic cyst.

(9) History of pancreatic surgery.

(~~5~~*10*) Current or history of metabolic liver disease, including but not limited to hemochromatosis (275.0), Wilson's disease (275.1), or alpha-1 anti-trypsin deficiency (273.4). *Gilbert's syndrome DOES meet the standard.*

(~~6~~*11*) Current enlargement of the liver from any cause (789.1).

e. Anorectal

(1) Current anal fissure or anal fistula (565).

(2) Current or history of anal or rectal polyp (569.0), prolapse (569.1), stricture (569.2), or fecal incontinence (787.6), within the last 2 years. *History of removal of juvenile or inflammatory polyp DOES meet the standard.*

(3) Current hemorrhoid (internal or external), when large, symptomatic, or with a history of bleeding (455) within the last 60 days.

~~f. Spleen~~

~~(1) Current splenomegaly (789.2).~~

~~(2) History of splenectomy (P41.5) (CPT 38100-38129), except when resulting from trauma.~~

~~g~~*f*. Abdominal Wall

(1) Current hernia (except for small or asymptomatic umbilical hernias), including but not limited to uncorrected inguinal (550) and other abdominal wall hernias (553).

(2) History of open or laparoscopic abdominal surgery (CPT 22900-22999, 43500-49999) during the preceding 6 months (P54). Uncomplicated laparoscopic appendectomies (CPT 44970) meet the standard after 3 months.

~~h~~*g*. Obesity. History of any gastrointestinal procedure for the control of obesity (CPT 43644-43645, 43770-43775, 43842-43848, 43886-43888) or artificial openings, including but not limited to ostomy (V44).

14. FEMALE GENITALIA

a. Current or history of abnormal ~~uterine bleeding (626.2)~~ *menstruation unresponsive to medical management within the last 12 months*, including but not limited to menorrhagia, metrorrhagia, or polymenorrhea.

b. ~~Current unexplained~~ *Primary* amenorrhea (626.0).

c. Current unexplained secondary amenorrhea (626.0).

~~c~~*d*. Current ~~or history of~~ dysmenorrhea (625.3) that is *unresponsive to medical therapy and is* incapacitating to a degree recurrently ~~necessitating~~ *requiring* absences of more than a few hours from routine activities.

~~d~~*e*. ~~Current or history of~~ *e*Endometriosis (617) *that is unresponsive to medical therapy*.

~~e~~*f*. History of major abnormalities or defects of the genitalia ~~such as~~ *including but not limited to* change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).

~~f~~*g*. ~~Current or history of~~ *Persistent or clinically significant* ovarian cyst(s) (620.2) ~~when persistent or symptomatic~~.

h. Polycystic ovarian syndrome (256.4) with metabolic complications.

~~g~~*i*. ~~Current~~ *p*Pelvic inflammatory disease (614) ~~or history of recurrent pelvic inflammatory disease. Current or history of chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9)~~ *within the preceding 30 days*.

j. Chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9).

~~h~~*k*. ~~Current~~ *p*Pregnancy (V22), ~~until~~ *through* 6 months after the ~~end~~ *completion* of the pregnancy (CPT 59150, 59151, 59400, 59409, 59510, 59514, 59610, 59612, 59812-59857).

~~i. History of congenital absence of the uterus (752.3).~~

~~j~~*l*. ~~Current~~ *Symptomatic* uterine enlargement due to any cause (621.2).

~~k~~*m*. Current or history of *g*enital infection or ulceration, including but not limited to herpes genitalis (054.11) or condyloma acuminatum (078.11), if of sufficient severity ~~requiring~~ *to require* frequent intervention or to interfere with normal function. *Herpes does not meet the standard if:*

(1) Current lesions are present.

(2) Chronic suppressive therapy is needed.

(3) There are three or more outbreaks per year.

(4) Any outbreak in the past 12 months interfered with normal function.

(5) Treatment included hospitalization or intravenous therapy.

~~l~~*n*. ~~Current or history of a~~*A*bnormal gynecologic cytology *within the preceding 2 years*, including but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix (795.0), excluding atypical squamous cells of undetermined significance without human papillomavirus (079.4) and confirmed low-grade squamous intraepithelial lesion (622.9). For the purposes of this Instruction, confirmation is by colposcopy or repeat cytology.

15. MALE GENITALIA

a. Absence of one or both testicles, congenital (752.89) or undescended (752.51). ~~Unilateral loss of a testis, unrelated to cancer, DOES meet the standard.~~

b. Current *or history of* epispadias (752.62) ~~or hypospadias (752.61), when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction~~.

c. Current or history of surgery for proximal hypospadias (752.61).

d. Distal (coronal) hypospadias without history of surgery DOES meet the standard.

e. Distal (coronal) hypospadias treated with surgery when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction.

~~c~~*f*. Current enlargement or mass of testicle ~~or~~, epididymis (608.9), *or spermatic cord*.

~~d~~*g*. Current *or history of recurrent* orchitis or epididymitis (604.90).

~~e~~*h*. History of penis amputation (878.0) (CPT 54125, 54130-54135).

i. Current penile curvature if associated with pain.

~~f~~*j*. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.13) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function. *Herpes does not meet the standard if:*

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

(3) There are three or more outbreaks per year.

(4) Any outbreak in the past 12 months interfered with normal function.

(5) Treatment included hospitalization or intravenous therapy.

k. Current or history of urethral condyloma acuminatum.

~~g~~*l*. Current acute prostatitis (601.0) ~~or~~, chronic prostatitis (601.1), *or chronic pelvic pain syndrome*.

~~h~~*m*. Current hydrocele (603) ~~with greatest dimension of 4 centimeters or greater or symptomatic~~ *or spermatacele associated with pain or which precludes a complete exam of the scrotal contents*.

~~i~~*n*. Left varicocele (456.4), if *painful or* symptomatic, or associated with testicular atrophy, or varicocele larger than the testis.

o. Left varicocele (456.4) that does not reduce or decompress completely when supine.

~~j~~*p*. ~~Any~~ *Bilateral or* right varicocele (456.4).

~~k~~*q*. Current or history of chronic *or recurrent* scrotal pain or unspecified symptoms associated with male genital organs (608.9).

~~l~~*r*. History of major abnormalities or defects of the genitalia such as change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).

16. URINARY SYSTEM

a. Current ~~cystitis,~~ or history of chronic ~~or~~/ recurrent cystitis (595), *interstitial cystitis, or painful bladder syndrome*.

b. Current urethritis, or history of chronic or recurrent urethritis (597.80).

c. History ~~of enuresis (788.30) or incontinence of urine (788.30), or the control of it with medication or other treatment past the 15th birthday.~~ *or treatment of the following voiding symptoms within the previous 12 months:*

(1) Urinary frequency or urgency more than every 2 hours on a daily basis.

(2) Nocturia more than two episodes during sleep period.

(3) Enuresis (788.30).

(4) Incontinence of urine, such as urge or stress.

(5) Urinary retention.

(6) Dysuria.

d. History of need for urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

e. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.

~~d~~*f*. Current ~~hematuria (599.7), pyuria, or other findings indicative of urinary tract disease (599).~~ *or history of abnormal urinary findings:*

(1) Gross hematuria (599.7).

(2) Microscopic hematuria (3 or more red blood cells per high-powered field on 2 of 3 properly collected urinalyses).

(3) Pyuria (6 or more white blood cells per high-powered field in 2 or 3 properly collected urinalyses).

~~e~~*g*. Current or recurrent urethral *or ureteral* stricture (598) or fistula (599.1) *involving the urinary tract*.

~~f~~*h*. Conditions associated with the kidneys, including:

(1) Current absence of one kidney, congenital (753.0) or acquired (V45.73) (CPT 50220-50236).

(2) Asymmetry in size or function of kidneys.

(3) History of renal transplant.

(~~2~~*4*) Current *chronic or recurrent* pyelonephritis (590.0) ~~(chronic or recurrent),~~ or any other unspecified infections of the kidney (590.9).

(~~3~~*5*) Current or history of polycystic kidney (753.1).

(~~4~~*6*) Current or history of horseshoe kidney (753.3).

(~~5~~*7*) Current or history of hydronephrosis (591).

(~~6~~*8*) Current or history of acute (580) *nephritis* or chronic (582) ~~nephritis~~ *kidney disease* of any type.

(9) History of acute kidney injury requiring dialysis.

(~~7~~*10*) Current or history of proteinuria (791.0) ~~greater than 200 milligrams in 24 hours or~~ *with* a protein-to-creatinine ratio greater than 0.2 in a random urine sample~~, if greater~~ *more* than 48 hours after strenuous activity~~, unless consultation determines the condition to be benign orthostatic proteinuria~~. *Benign orthostatic proteinuria MEETS the standard.*

(~~8~~*11*) Current or history of *symptomatic* urolithiasis (592) within the preceding 12 months. ~~Recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.~~

(12) History of stone(s) greater than 4mm in size, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.

(13) History of urolithiasis requiring surgical treatment or intervention requiring hospitalization.

17. SPINE AND SACROILIAC JOINTS

a. Ankylosing spondylitis or other inflammatory spondylopathies (720).

b. Current or history of any condition, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:

(1) It prevents the individual from successfully following a physically active vocation in civilian life (724), or is associated with local or referred pain to the extremities, muscular spasms, postural deformities, or limitation in motion.

(2) It requires external support.

(3) It requires limitation of physical activity or frequent treatment.

c. Current deviation or curvature of spine (737) from normal alignment, structure, or function if:

(1) It prevents the individual from following a physically active vocation in civilian life.

(2) It interferes with the proper wearing of a uniform or military equipment.

(3) It is symptomatic.

(4) There is lumbar or thoracic scoliosis greater than 30 degrees, or kyphosis and lordosis greater than 50 degrees when measured by the Cobb Method.

d. History of congenital fusion (756.15) involving more than two vertebral bodies or any surgical fusion of spinal vertebrae (P81.0) (CPT 22532-22812).

e. Current or history of fracture or dislocation of the vertebra (805).

(1) Vertebral fractures that do NOT meet the standard:

(a) Compression fractures involving more than or equal to 25 percent of a single vertebra.

(b) Compression fractures involving less than 25 percent of a single vertebra occurring within the past 12 months or it is symptomatic.

(c) Any compression fracture that is symptomatic.

(2) Vertebral fractures that DO MEET the standard:

(a) Compression fractures involving less than 25 percent of a single vertebra if it occurred more than 1 year before the accession examination and the applicant is asymptomatic.

(b) A history of fractures of the transverse or spinous process IF the applicant is asymptomatic.

f. History of juvenile epiphysitis (732.6) with any degree of residual change indicated by X-ray or kyphosis.

g. Current herniated nucleus pulposus (722) or history of surgery to correct (CPT 63001-63200). A surgically corrected asymptomatic single-level lumbar or thoracic diskectomy with full resumption of unrestricted activity DOES meet the standard.

h. Current or history of spina bifida (741) when symptomatic, when there is more than one vertebral level involved, or with dimpling of the overlying skin. History of surgical repair of spina bifida.

i. Current or history of spondylolysis congenital (756.10-756.12) or acquired (738.4).

j. Current or history of spondylolisthesis congenital (756.12) or acquired (738.4).

18. UPPER EXTREMITIES

a. Limitation of Motion. Current active joint ranges of motion less than:

(1) Shoulder (726.1)

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) Elbow (726.3)

(a) Flexion to 130 degrees.

(b) Extension to 15 degrees.

(3) Wrist (726.4). A total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined arc 30 degrees.

(4) Hand (726.4)

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and Thumb (726.4). Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Fingers

(1) Absence of the distal phalanx of either thumb (885).

(2) Absence of any portion of the index finger.

(3) Absence of distal and middle phalanx of the middle or ring finger of either hand irrespective of the absence of the little finger (886).

(4) Absence of more than the distal phalanx of any two of the following: index, middle, or ring finger of either hand (886).

(5) Absence of hand or any portion thereof (887), except for specific absence of fingers as noted in subparagraphs 18.b.(1)-(4).

(6) Current polydactyly (755.0).

(7) Intrinsic paralysis or weakness of upper limbs, including but not limited to nerve paralysis, carpal tunnel and cubital syndromes, lesion of ulnar, median, or radial nerve (354), sufficient to produce physical findings in the hand such as muscle atrophy and weakness.

c. Residual Weakness and Pain. Current disease, injury, or congenital condition with residual weakness or symptoms that prevents satisfactory performance of duty, including but not limited to chronic joint pain associated with the shoulder (719.41), the upper arm (719.42), the forearm (719.43), and the hand (719.44); or chronic joint pain as a late effect of fracture of the

upper extremities (905.2), as a late effect of sprains without mention of injury (905.7), and as late effects of tendon injury (905.8).

19. LOWER EXTREMITIES

a. General

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh (719.45), lower leg (719.46), knee (717.9), ankle and or foot (719.47) that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life, or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty.

(2) Current leg-length discrepancy resulting in a limp (736.81).

b. Limitation of Motion. Current active joint ranges of motion less than:

(1) Hip (due to disease (726.5) or injury (905.2))

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

(c) Extension to 10 degrees (beyond 0 degrees).

(d) Abduction to 45 degrees.

(e) Rotation of 60 degrees (internal and external combined).

(2) Knee (due to disease (726.6) or injury (905.4))

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle (due to disease (726.7) or injury (905.4) or congenital)

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle

(1) Current absence of a foot or any portion thereof (896).

(2) Absence of a single lesser toe or any portion thereof that is asymptomatic and does not impair function DOES meet the standard.

(3) Deformity of the toes (735.9) that prevents the proper wearing of military footwear or impairs walking, marching, running, maintaining balance, or jumping.

(4) Symptomatic deformity of the toes (acquired (735) or congenital (755.66)), including but not limited to conditions such as hallux valgus (735.0), hallux varus (735.1), hallux rigidus (735.2), hammer toe(s) (735.4), claw toe(s) (735.5), or overriding toe(s) (735.8).

(5) Clubfoot (754.70) or pes cavus (754.71) that prevents the proper wearing of military footwear or causes symptoms when walking, marching, running, or jumping.

(6) Rigid or symptomatic pes planus (acquired (734) or congenital (754.61)).

(7) Current ingrown toenails (703.0), if infected or symptomatic.

(8) Current or history of recurrent plantar fasciitis (728.71).

(9) Symptomatic neuroma (355.6).

d. Leg, Knee, Thigh, and Hip

(1) Current loose or foreign body in the knee joint (717.6).

(2) History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury.

(3) History of surgical reconstruction of knee ligaments (P81.4) (CPT 27427-27429) DOES meet the standard if 12 months has elapsed since reconstruction, and the knee is asymptomatic and stable.

(4) Recurrent ACL reconstruction (CPT 27427, 27407).

(5) Symptomatic medial (717.82) or lateral (717.42) meniscal injury. The following DOES meet the standard if asymptomatic and released to full and unrestricted activity:

(a) Meniscal repair (CPT 27403), more than 6 months after surgery.

(b) Partial meniscectomy (CPT 27332-27333) more than 3 months after surgery.

(6) Meniscal transplant (CPT 29868).

(7) Symptomatic medial (844.1) and lateral (844.0) collateral ligament instability.

(8) Current or history of congenital dislocation of the hip (754.3), osteochondritis of the hip (Legg-Calve-Perthes Disease) (732.1), or slipped capital femoral epiphysis of the hip (732.2).

(9) Hip dislocation (835) within 2 years preceding examination. Hip dislocation after 2 years DOES meet the standard if asymptomatic and released to full unrestricted activity.

(10) Symptomatic osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) (732.4) within the past year.

(11) Stress fractures (733.95, V13.52), recurrent or single episode during the past year.

20. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES

a. Current or history of chondromalacia (717.7), including but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome (719.46), osteoarthritis (715.3), or traumatic arthritis (716.1).

b. Current joint dislocation if unreduced, or history of recurrent dislocation, subluxation or instability of the hip (835), elbow (832), ankle (837), or foot.

c. History of any dislocation, subluxation or instability of the knee (718.86) or shoulder.

d. Current or history of osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints that has interfered with a physically active lifestyle, or that prevents the satisfactory performance of military duty.

e. Fractures

(1) Current malunion or non-union of any fracture (733.8) (except asymptomatic ulnar styloid process fracture).

(2) Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or interferes with proper wearing of equipment or military uniform. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.

f. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities (V43).

g. Current or history of contusion of bone or joint (923, 924), ; an injury of more than a minor nature that shall interfere or prevent performance of military duty, or shall require frequent or prolonged treatment, without fracture, nerve injury, open wound, crush, or dislocation, that occurred in the preceding 6 months and recovery has not been sufficiently completed or rehabilitation resolved.

h. History of joint replacement or resurfacing of any site (V43.6) (CPT 24363, 27130-27132, 27447).

i. Current or history of neuromuscular paralysis, weakness, contracture, or atrophy (728) of sufficient degree to interfere with or prevent satisfactory performance of military duty, or requires frequent or prolonged treatment.

j. Current symptomatic osteochondroma or history of multiple osteocartilaginous exostoses (727.82).

k. Current osteoporosis (733.0) as demonstrated by a reliable test such as a dual energy x-ray absorptiometry scan (DEXA).

l. Current osteopenia (733.9) until resolved.

m. Current osteomyelitis (730.0) or history of recurrent osteomyelitis.

n. Current or history of *osteochondral defect, formerly known as* osteochondritis dissecans (732.7).

o. History of cartilage surgery, including but not limited to cartilage debridement, chondroplasty, microfracture, or cartilage transplant procedure (CPT 20910, 20912, 21230, 21235, 27412, 27415, 29866-29867).

p. Current or history of any post-traumatic (958.9) or exercise-induced (729.7-79) compartment syndrome.

q. Current or history of avascular necrosis of any bone.

r. Current or history of recurrent tendon disorder, including but not limited to tendonitis, tendonopathy, tenosynovitis.

21. VASCULAR SYSTEM

a. Current or history of abnormalities of the arteries (447), including but not limited to aneurysms (442), arteriovenous malformations, atherosclerosis (440), or arteritis (such as Kawasaki's disease) (446).

b. Current or medically managed hypertension (401). Hypertension is defined as systolic pressure greater than 140 mmHg and or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure cuff averaged over two or more properly measured, seated, blood pressure readings on each of 2 or more consecutive days (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 or more consecutive days).

c. Current or history of peripheral vascular disease (443.9), including but not limited to diseases such as Raynaud's Disease (443.0) and vasculidities.

d. Current or history of venous diseases, including but not limited to recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454).

e. Current or history of deep venous thrombosis (453.40).

f. History of operation or endovascular procedure on the arterial or venous systems, including but not limited to vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement (CPT 34001-37799).

g. History of Marfan's Syndrome (759.82).

22. SKIN AND CELLULAR TISSUES

a. Current diseases of sebaceous glands including severe and or cystic acne (706), or hidradenitis suppurativa (704-705), if extensive involvement of the neck, scalp, axilla, groin, shoulders, chest, or back is present or shall be aggravated by or interfere with the proper wearing of military equipment. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (Accutane®), do not meet the standard until 8 weeks after completion of therapy.

b. Current or history of atopic dermatitis (691) or eczema (692.9) after the 12th birthday.

(1) Atopic Dermatitis. Active or history of residual or recurrent lesions in characteristic areas (face, neck, antecubital and or popliteal fossae, occasionally wrists and hands).

(2) Non-Specific Dermatitis. Current or history of recurrent or chronic non-specific dermatitis to include contact (692) (irritant or allergic), or dyshidrotic dermatitis (705.81) requiring more than treatment with over the counter medications.

c. Cysts if:

(1) The current cyst (706.2) (other than pilonidal cyst) is of such a size or location as to interfere with the proper wearing of military equipment.

(2) The current pilonidal cyst (685) is evidenced by the presence of a tumor mass or a discharging sinus, or is a surgically resected pilonidal cyst (CPT 11770-11772) that is symptomatic, unhealed, or less than 6 months post-operative.

d. Current or history of bullous dermatoses (694), including but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa, (757.39). Resolved bullous impetigo DOES meet the standard.

e. Current or chronic lymphedema (457.1).

f. Current or history of furunculosis or carbuncle (680) if extensive, recurrent, or chronic.

g. Current or history of severe hyperhidrosis of hands or feet (705.2, 780.8) unless controlled by topical medications.

h. Current or history of congenital (757) or acquired (216) anomalies of the skin, such as nevi or vascular tumors that interfere with function, or are exposed to constant irritation. History of Dysplastic Nevus Syndrome (232).

i. Current or history of keloid formation (701.4), including but not limited to pseudofolliculitis and keloidalis nuchae (706.1), if that tendency is marked or interferes with the proper wearing of military equipment.

j. Current lichen planus (cutaneous and/or oral) (697.0).

k. Current or history of neurofibromatosis (Von Recklinghausen's Disease) (237.7).

l. History of photosensitivity (692.72), including but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus.

m. Current or history of psoriasis (696.1).

n. Current or history of radiodermatitis (692.82).

o. Current or history of scleroderma (710.1).

p. Current or history of chronic urticaria lasting longer than 6 weeks or recurrent episodes of urticaria (708.8) within the past 24 months not associated with angioedema, hereditary angioedema (277.6), or maintenance therapy for chronic urticaria, even if not symptomatic.

q. Current symptomatic plantar wart(s) (078.19).

r. Current scars (709.2), or any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, which in the opinion of the certifying authority shall interfere with proper wearing of military clothing or equipment, or which exhibits a tendency to ulcerate or interferes with the satisfactory performance of duty.

s. Prior burn (949) injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with the satisfactory performance of military duty due to decreased range of motion, strength, or agility.

t. Current localized types of fungus infections (117), interfering with the proper wearing of military equipment or the performance of military duties. For systemic fungal infections, refer to paragraph 24.~~w~~*q*. of this enclosure.

23. BLOOD AND BLOOD-FORMING TISSUES

a. Current hereditary or acquired anemia, which has not been corrected with therapy before appointment or induction. ICD-9 codes for diagnosed anemia include hereditary hemolytic anemia (282), sickle cell disease (282.6), acquired hemolytic anemia (283), aplastic anemia (284), or unspecified anemias (285).

b. Current or history of coagulation defects (286), including but not limited to von Willebrand's Disease (286.4), idiopathic thrombocytopenia (287), or Henoch-Schönlein Purpura (287.0).

c. Current or history of diagnosis of any form of chronic or recurrent agranulocytosis and/or leukopenia (288.0).

d. Spleen

(1) Current splenomegaly (789.2).

(2) History of splenectomy (P41.5) (CPT 38100-38129), except when accomplished for trauma or conditions unrelated to the spleen or for hereditary spherocytosis (282.0).

24. SYSTEMIC

a. Current or history of disorders involving the immune mechanism, including immunodeficiencies (279).

b. Presence of human immunodeficiency virus or serologic evidence of infection (042, V08) or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing.

~~c. Current or history of lupus erythematosus (710.0) or mixed connective tissue disease variant (710.9).~~

~~d. Current or history of progressive systemic sclerosis (710.1), including Calcinosis, Raynaud's phenomenon, Esophogeal dysmotility, sclerodactyly, telangiectasia (CREST) Variant.~~

~~e. Current or history of Reiter's disease (099.3).~~

~~f. Current or history of rheumatoid arthritis (714.0).~~

~~g. Current or history of Sjögren's syndrome (710.2).~~

~~h. Current or history of vasculitis, including but not limited to polyarteritis nodosa and allied conditions (446.0), arteritis (447.6), Behçet's (136.1), and Wegener's granulomatosis (446.4).~~

~~i~~*c*. Tuberculosis (010)

(1) Current active tuberculosis or substantiated history of active tuberculosis in any form or location, regardless of past treatment, in the previous 2 years.

(2) Current residual physical or mental defects from past tuberculosis that shall prevent the satisfactory performance of duty.

(3) Individuals with a past history of active tuberculosis more than 2 years before appointment, enlistment, or induction meet the standard if they have received a complete course of standard chemotherapy for tuberculosis.

(4) Current or history of untreated latent tuberculosis (positive Purified Protein Derivative with negative chest X-ray) (795.5). Individuals with a tuberculin reaction in accordance with ATS and United States Public Health Service (USPHS) guidelines are eligible for enlistment, induction, and appointment, provided they have received chemoprophylaxis in accordance with ATS and USPHS guidelines. A negative QuantiFERON®-TB Gold (QFT®-G) with a positive tuberculin skin test DOES meet the standard.

~~j~~*d*. Current untreated syphilis (097).

~~k~~*e*. History of anaphylaxis (995.0).

(1) History of anaphylaxis to stinging insects (989.5). A cutaneous only reaction to a stinging insect under the age of 16 DOES meet the standard. Applicants who have been treated for 3-5 years with maintenance venom immunotherapy DO meet the standard.

(2) History of systemic allergic reaction to food or food additives (995.60-995.69). Systemic allergic reaction may be defined as a temporally related, systemic, often multi-system, reaction to a specific food. The presence of a food-specific immunoglobulin E antibody without a correlated clinical history DOES meet the standard.

(3) Oral allergy syndrome.

(4) Hypersensitivity to latex (V15.07).

(5) Exercise-induced anaphylaxis (with or without food).

(6) Idiopathic anaphylaxis (995.0).

(7) Acute, early, or immediate anaphylactic onset.

(8) History of systemic allergic reaction or angioedema.

~~l~~*f*. Current residual of tropical fevers, including but not limited to fevers, such as malaria (084) and various parasitic or protozoan infestations that prevent the satisfactory performance of military duty.

~~m~~*g*. History of malignant hyperthermia (995.86).

~~n~~*h*. History of industrial solvent or other chemical intoxication (982) with sequelae.

~~o~~*i*. History of motion sickness (994.6) resulting in recurrent incapacitating symptoms or of such a severity to require pre-medication in the previous 3 years.

~~p~~*j*. History of rheumatic fever (390).

~~q~~*k*. Current or history of muscular dystrophies (359) or myopathies.

~~r~~*l*. Current or history of amyloidosis (277.3).

~~s~~*m*. Current or history of eosinophilic granuloma (277.8) and all other forms of histiocytosis (202.3). Healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, DOES meet the standard.

~~t~~*n*. Current or history of polymyositis (710.4) or dermatomyositis complex (710.3) with skin involvement.

~~u~~*o*. History of rhabdomyolysis (728.88).

~~v~~*p*. Current or history of sarcoidosis (135).

~~w~~*q*. Current systemic fungus infections (117). For localized fungal infections, refer to paragraph 22.t. of this enclosure.

25. ENDOCRINE AND METABOLIC

a. Current ~~or history of~~ adrenal dysfunction (255).

b. ~~Current or history of diabetes mellitus (249.xx, 250.xx).~~ *Diabetes mellitus (250) disorders, including:*

(1) Current or history of diabetes mellitus (250).

(2) Current or history of pre-diabetes mellitus defined as fasting plasma glucose 110-125 milligrams per deciliter (mg/dL) and glycosylated hemoglobin greater than 5.7 percent.

(3) History of gestational diabetes mellitus.

(4) Current persistent glycosuria, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4).

c. Current or history of pituitary dysfunction (253), *to include history of growth hormone use. Non-functional microadenoma (less than 1cm) DOES meet the standard.*

d. Current or history of ~~gout (274).~~ *diabetes insipidus.*

e. Current or history of hyperparathyroidism (252.0) or hypoparathyroidism (252.1).

f. The following thyroid disorders:

(1) Current goiter (240). *Symmetrical simple goiter less than two times normal size with no nodules by ultrasound and normal thyroid function tests DOES meet the standard.*

(2) Thyroid nodule (241.0). A solitary thyroid nodule less than 5mm or less than 3cm with benign histology or cytology DOES meet the standard.

(~~2~~*3*) Current hypothyroidism (244) ~~uncontrolled by medication~~. *Individuals with two normal thyroid stimulating hormone tests within the preceding 6 months DOES meet the standard.*

(~~3~~*4*) Current or history of hyperthyroidism (242.9). *In remission off of anti-thyroidal medication with normal thyroid function tests for a minimum of 12 months and without evidence of thyroid associated ophthalmopathy DOES meet the standard.*

~~(4) Current thyroiditis (245).~~

g. Current nutritional deficiency diseases, including but not limited to beriberi (265.0), pellagra (265.2), and scurvy (267).

~~h. Current persistent glucosuria, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4).~~

~~i.~~*h.* Current or history of acromegaly, including but not limited to gigantism (253.0), or other disorders of pituitary function (253).

~~j.~~*i.* Dyslipidemia ~~on medical management requiring more than one medication.~~ *with low-density lipoprotein (LDL) greater than 200mg/dL or triglycerides greater than 400 mg/dL. Dyslipidemia requiring more than one medication or LDL greater than 190 mg/dL on therapy.* All those on medical management must have demonstrated no medication side effects (such as myositis, myalgias, or transaminitis) for a period of 6 months.

~~k.~~*j.* Metabolic syndrome beyond the 35th birthday. Metabolic syndrome is defined in accordance with NHLBI and American Heart Association (2005) as any three of the following:

(1) Medically controlled hypertension or elevated blood pressure of greater than 130 mmHg systolic or greater than 85 mmHg diastolic.

(2) Waist circumference greater than 35 inches for women and greater than 40 inches for men.

(3) Medically controlled dyslipidemia or triglycerides greater than 150 mg/dl.

(4) Medically controlled dyslipidemia or high-density lipoprotein less than 40 mg/dl in men or less than 50 mg/dl in women.

(5) Fasting glucose greater than 100 mg/dl.

k. Metabolic bone disease.

(1) Osteopenia, osteoporosis, or low bone mass with history of fragility fracture.

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

l. Male hypogonadism.

m. Current or history of islet-cell tumors, nesideoblastosis, or hypoglycemia.

26. RHEUMATOLOGIC

a. Current or history of lupus erythematosus (710.0) or mixed connective tissue disease variant (710.9).

b. Current or history of progressive systemic sclerosis (710.1), including calcinosis, Raynaud's disease or phenomenon, esophogeal dysmotility, sclerodactyly, telangiectasia (CREST) variant.

c. Current or history of Reiter's disease (099.3).

d. Current or history of rheumatoid arthritis (714.0).

e. Current or history of Sjögren's syndrome (710.2).

f. Current or history of vasculitis, including but not limited to polyarteritis nodosa and allied conditions (446.0), arteritis (447.6), Behçet's (136.1), and Wegener's granulomatosis (446.4). Henoch-Schonlein Purpura occurring before the age of 19 with 2 years remission and no sequelae DOES meet the standard.

g. History of congenital fusion (756.15) involving more than two vertebral bodies or any surgical fusion of spinal vertebrae (P81.0).

h. Current or history of gout (274).

i. Current or history of inflammatory myopathy including polymyositis or dermatomyositis.

j. Current or history of non-inflammatory myopathy to include but not limited to metabolic myopathy such as glycogen storage disease, lipid storage disease, and mitochondrial myopathy.

k. Current or history of fibromyalgia, myofascial pain, or chronic wide-spread pain.

l. Current or history of chronic fatigue syndrome.

m. Current or history of spondyloarthritis including ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis, or spondyloarthritis associated with inflammatory bowel disease.

n. Current or history of joint hypermobility syndrome.

o. Current or history of hereditary connective tissue disorders including but not limited to Marfan's syndrome, Ehlers-Danlos syndrome, and osteogenesis imperfecta.

2~~6~~*7*. NEUROLOGIC

a. Current or history of cerebrovascular conditions, including but not limited to subarachnoid (430) or intracerebral (431) hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation (437).

b. History of congenital or acquired anomalies of the central nervous system (742) or meningocele (741.9).

c. Current or history of disorders of meninges, including but not limited to cysts (349.2). Asymptomatic incidental arachnoid cyst demonstrated to be stable by neurological imaging over a 6-month or greater time period DO meet the standard.

d. Current or history of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), peripheral nerves (337), or muscles (728).

e. History of headaches (784.0), including but not limited to migraines (346) and tension headaches (307.81) that:

(1) Are severe enough to disrupt normal activities (such as loss of time from school or work) ~~of~~ more than twice per year in the past 2 years.

(2) Require prescription medications more than twice per year within the last 2 years.

f. Migraine (346) or migraine variant (346.2) associated with neurological deficits other than scotoma.

g. Cluster headaches (339.0).

h. History of head injury (854.0) if associated with:

(1) Post-traumatic seizure(s) occurring more than 30 minutes after injury.

(2) Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit.

(3) Persistent impairment of cognitive function.

(4) Persistent alteration of personality or behavior.

(5) Unconsciousness of 24 hours or more post-injury

(6) Amnesia or disorientation of person, place, or time of 7 days duration or longer post-injury.

(7) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging until resolved and 12 months has elapsed since injury.

(8) Associated abscess (326) or meningitis (958.8).

(9) Cerebrospinal fluid rhinorrhea (349.81) or otorrhea (388.61) persisting more than 7 days.

(10) Penetrating brain injury to include radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.

i. History of moderate head injury (854.03).

(1) Moderate head injuries are defined as:

(a) Unconsciousness of more than 30 minutes but less than 24 hours, or

(b) Amnesia, or disorientation of person, place, or time, alone or in combination, more than 24 hours but less than 7 days duration post-injury, or

(c) Linear skull fracture.

(2) After 12 months post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complications.

j. History of mild head injury (854.02).

(1) Mild head injury is defined as:

(a) Unconsciousness of less than 30 minutes post-injury.

(b) Amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.

(2) After 1 month post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complications.

k. History of persistent post-concussive symptoms (310.2) that interfere with normal activities or have duration of more than 1 month. Such symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

l. Current or history of infectious processes of the central nervous system, including but not limited to meningitis (322), encephalitis (323), neurosyphilis (094), or brain abscess (324), if occurring within 1 year before examination, required surgical treatment, or if there are residual neurological defects.

m. Current or history of paralysis, weakness, lack of coordination, chronic pain (including but not limited to chronic regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes (344), including but not limited to Guillain-Barre Syndrome (357.0).

n. Any seizure occurring beyond the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal sleep-deprived electroencephalogram and normal neurology evaluation while taking no medications for seizure control.

o. Chronic nervous system disorders, including but not limited to myasthenia gravis (358.0), multiple sclerosis (340), tremor (333.1), and tic disorders (307.20) (e.g., Tourette's (307.23)).

p. Current or history of central nervous system shunts of all kinds (V45.2).

q. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope (780.2), including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.

2~~7~~*8*. SLEEP DISORDERS

a. Chronic insomnia (780.5). Within the past year, had difficulty sleeping, or used medications to promote sleep for more than 3 nights per week, over a period of 3 months.

b. Sleep-related breathing disorders (327). Current diagnosis or treatment of sleep-related breathing disorders, including but not limited to sleep apnea (327.2).

c. Current or history of narcolepsy, cataplexy (347-347.11), or other hypersomnia disorders (327.13-19).

d. Circadian rhythm disorders requiring treatment (307.45).

e. Current or history of parasomnia (327.44, 327.49), including but not limited to sleepwalking, enuresis, or night terrors (307.46), after the age of 15.

f. Current diagnosis or treatment of sleep-related movement disorders to include restless leg syndrome (327.5).

2~~8~~*9*. LEARNING, PSYCHIATRIC, AND BEHAVIORAL

a. Attention Deficit Hyperactivity Disorder (ADHD) (314) UNLESS the following criteria are met:

(1) The applicant has not required an Individualized Education Program or work accommodations since the age of 14.

(2) There is no history of comorbid mental disorders.

(3) The applicant has never taken more than a single daily dosage of medication or has not been prescribed medication for this condition for more than 24 cumulative months after the age of 14.

(4) During periods off of medication after the age of 14, the applicant has been able to maintain at least a 2.0 grade point average without accommodations.

(5) Documentation from the applicant's prescribing provider that continued medication is not required for acceptable occupational or work performance.

(6) Applicant is required to enter service and pass Service-specific training periods with no prescribed medication for ADHD.

b. History of learning disorders (315), including but not limited to dyslexia (315.02), UNLESS applicants demonstrated passing academic and employment performance without utilization of academic and or work accommodations at any time since age 14.

c. Pervasive developmental disorders (299 series) including Asperger Syndrome, autistic spectrum disorders, and pervasive developmental disorder-not otherwise specified (299.9).

d. Current or history of disorders with psychotic features such as schizophrenic disorders (295), delusional disorders (297), or other and unspecified psychoses (298).

e. History of bipolar disorders (296.4-7) and affective psychoses (296.8).

f. History of depressive disorders, including but not limited to major depression (296), dysthymic disorder (300.4), and cyclothymic disorder requiring outpatient care for longer than 12 months by a physician or other mental health professional (to include V65.40), or any inpatient treatment in a hospital or residential facility.

g. Depressive disorder not otherwise specified (311), or unspecified mood disorder (296.90), UNLESS:

(1) Outpatient care was not required for longer than 24 months (cumulative) by a physician or other mental health professional (to include V65.40).

(2) The applicant has been stable without treatment for the past 36 continuous months.

(3) The applicant did not require any inpatient treatment in a hospital or residential facility.

h. History of a single adjustment disorder (309) within the previous 3 months, or recurrent episodes of adjustment disorders.

i. Current or history of disturbance of conduct (312), impulse control (312.3), oppositional defiant (313.81), other behavior disorders (313), or personality disorder (301).

(1) History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups), interview, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in the Military Services.

(2) Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to military service.

j. Encopresis (307.7) after 13th birthday.

k. History of anorexia nervosa (307.1) or bulimia (307.51).

l. Other eating disorders (307.50; 52-54) including unspecified disorders of eating (307.59) occurring after the 13th birthday.

m. Any current receptive or expressive language disorder, including but not limited to any speech impediment or stammering and stuttering (307.0) of such a degree as to significantly interfere with production of speech or *the ability* to repeat commands.

n. History of suicidal behavior, including gesture(s) or attempt(s) (300.9) or history of self-mutilation or injury used as a way of dealing with life and emotions.

o. History of obsessive-compulsive disorder (300.3) or post-traumatic stress disorder (309.81).

p. History of anxiety disorders (300.01), anxiety disorder not otherwise specified (300.00), panic disorder (300.2), agoraphobia (300.21, 300.22), social phobia (300.23), simple phobias (300.29), other acute reactions to stress (308) UNLESS:

(1) The applicant did not require any treatment in an inpatient or residential facility.

(2) Outpatient care was not required for longer than 12 months (cumulative) by a physician or other mental health professional (to include V65.40).

(3) The applicant has not required treatment (including medication) for the past 24 continuous months.

(4) The applicant has been stable without loss of time from normal pursuits for repeated periods even if of brief duration; and without symptoms or behavior of a repeated nature that impaired social, school, or work efficiency for the past 24 continuous months.

q. Current or history of dissociative, conversion, or factitious disorders (300.1), depersonalization (300.6), hypochondriasis (300.7), somatoform disorders (300.8), or pain disorder related to psychological factors (307.80 and .89).

r. Current or history of psychosexual conditions (302), including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.

s. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305.0), or other drug abuse (305.2 thru 305.9).

t. Current or history of other mental disorders (all 290-319 not listed) that, in the opinion of the civilian or military medical examiner, shall interfere with or prevent satisfactory performance of military duty.

u. Prior psychiatric hospitalization for any cause.

~~29~~*30*. TUMORS AND MALIGNANCIES

a. Current benign tumors ~~(M8000)~~ or conditions that interfere with function, prevent the proper wearing of the uniform or protective equipment, shall require frequent specialized attention, or have a high malignant potential, such as Dysplastic Nevus Syndrome.

b. Current or history of malignant tumors (V10).

c. Skin cancer (other than malignant melanoma) that is removed with no residual DOES meet the standard.

3~~0~~*1*. MISCELLANEOUS

a. Current or history of parasitic diseases, if symptomatic or carrier state, including but not limited to filariasis (125), trypanosomiasis (086), schistosomiasis (120), hookworm (uncinariasis) (126.9), or unspecified infectious and parasitic disease (136.9).

b. Current or history of other disorders, including but not limited to cystic fibrosis (277.0) or porphyria (277.1), that prevent satisfactory performance of duty, or require frequent or prolonged treatment.

c. Current or history of cold-related disorders, including but not limited to frostbite, chilblain, immersion foot (991), or cold urticaria (708.2).

d. Current residual effects of cold-related disorders (991.9), including but not limited to paresthesias, easily traumatized skin, cyanotic amputation of any digit, ankylosis, trench foot, or deep-seated ache.

e. History of angioedema, including hereditary angioedema (277.6).

f. History of receiving organ or tissue transplantation (V42).

g. History of pulmonary (415) or systemic embolization (444).

h. History of untreated acute or chronic metallic poisoning, including but not limited to lead, arsenic, silver (985), beryllium (985.3), or manganese (985.2), or current complications or residual symptoms of such poisoning.

i. History of heat pyrexia (992.0), heatstroke (992.0), or sunstroke (992.0).

j. History of three or more episodes of heat exhaustion (992.3).

k. Current or history of a predisposition to heat injuries (992.0-992.8), including disorders of sweat mechanism (705.0-705.9), combined with a previous serious episode.

l. Current or history of any unresolved sequelae of heat injury (992.0-992.8), including but not limited to nervous, cardiac, hepatic, or renal systems.

m. Current or history of any condition that, in the opinion of the medical officer, shall significantly interfere with the successful performance of military duty or training (should use specific ICD code whenever possible, or 796.9).

n. Any current acute pathological condition, including but not limited to acute communicable diseases, until recovery has occurred without sequelae.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ADHD	Attention Deficit Hyperactivity Disorder
ANSI	American National Standards Institute
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ATS	American Thoracic Society
AV	atrioventricular
CPT	Current Procedural Terminology
CREST	Calcinosis, Raynaud's phenomenon, Esophogeal dysmotility, sclerodactyly, telangiectasia
dB	decibel
DEP	Delayed Entry Program
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DUSD(MPP)	Deputy Under Secretary of Defense for Military Personnel Policy
ECG	electrocardiograph
GERD	Gastro-Esophageal Reflux Disease
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
ICD	International Classification of Diseases
LASEK	laser epithelial keratomileusis
LASIK	laser-assisted in situ keratomileusis
LDL	*low-density lipoprotein*
LTBI	latent tuberculosis infection
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dl	milligrams per deciliter
mmHg	millimeters of mercury
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health
PRK	photorefractive keratectomy
PDASD(HA)	Principal Deputy Assistant Secretary of Defense for Health Affairs
PDES	Physical Disability and Evaluation System
PDUSD(P&R)	Principal Deputy Under Secretary of Defense for Personnel and Readiness

QFT®-G	QuantiFERON®-TB Gold
ROTC	Reserve Officer Training Corps
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USPHS	United States Public Health Service
WPW	Wolff-Parkinson-White

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this Instruction.

anemia. A hemoglobin level of less than 13.5 for males and less than 12 for females.

Department of Health and Human Services (HHS). The U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Military Department. Defined in Joint Publication 1-02 (Reference (j)).

Military Service(s). Defined in Reference (j).

NHLBI. An agency within the National Institutes of Health (NIH) that provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.

NIH. An agency within the HHS that serves as the steward of medical and behavioral research for the Nation. Its mission is science in pursuit of fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability.

QFT®-G. An in vitro laboratory diagnostic test using a whole blood specimen. It is an indirect test for Mycobacterium tuberculosis-complex (i.e., M. tuberculosis, M. bovis, M. africanum, M. microti, M. canetti) infection, whether tuberculosis disease or latent tuberculosis infection (LTBI). It cannot distinguish between tuberculosis disease and LTBI, and is intended for use in conjunction with risk assessment, radiography, and other medical and diagnostic evaluations.

EXHIBIT 13

PUNCHING THROUGH BARRIERS: FEMALE CADETS INTEGRATED INTO MANDATORY BOXING AT WEST POINT

MAJ. ALEX BEDARD (/PEOPLE/MAJ-ALEX-BEDARD)
MAJ. ROBERT "PETE" PETERSON (/PEOPLE/MAJ-ROBERT-PETE-PETERSON)
RAY "COACH" BARONE (/PEOPLE/RAY-COACH-BARONE)

Thursday, November 16, 2017

The Modern Army Combatives Program teaches hand-to-hand combative skills for the Army, and has greatly increased close-quarters combat training and proficiency. With inclusion into professional military education and widespread official tournaments, the program has also improved the Warrior Ethos, confidence and lethality of our force.

Although striking is part of the program's curriculum, its focus remains on grappling skills due to risk-mitigation factors. Unrestricted striking, like that in the sport of boxing, is typically reserved for more advanced combatives training and competition. For over a century, the boxing program at the U.S. Military Academy has successfully trained cadets in boxing through a deliberate risk-mitigation process, balancing safety and realism while meeting training objectives. The academy recently conducted gender integration of the boxing program, requiring all cadets to complete boxing to graduate, removing one of the last existing gender barriers in the U.S. Army.

This unique requirement offers many benefits that are not fully realized through combatives. Commanders, NCOs and Master Combatives Trainers throughout the Army can improve their combatives programs by learning about the boxing risk-mitigation process used at West Point and how the program was adjusted to accommodate both genders. This training can continue to improve the combat readiness of the Army for all genders.

The boxing program at West Point has been continually refined and adapted to balance meeting training objectives while ensuring the safety of cadets. The course is taught through 19 blocks of instruction lasting 50 minutes each. Cadets are evaluated in one-on-one, full contact, graded bouts consisting of two rounds that last a minute each.

Female cadets at the U.S. Military Academy box in class for a grade.

(Credit: U.S. Army/John Pellino)

Fear Factor

Boxing at West Point is the only mandatory activity that pits one cadet against another in full body contact. It teaches fear management, which is a necessary skill to lead soldiers in the crucible of ground combat. Striking to the head, like in boxing,

increases the perceived threat of physical harm. This invokes a strong physiological and psychological response from participants, similar to that experienced in ground combat.

The fear response in boxing is much greater than the fear associated with ground combatives, where one can simply tap and quit when placed in a fearful or uncomfortable position. In boxing, there is no opportunity to tap out against an overbearing and aggressive opponent. Through boxing, cadets learn to manage fear and perform physically despite the presence of these stressors, a quality that is necessary for combat leadership.

Women were first admitted to West Point in 1976. Concerns over gender differences resulted in women initially having to complete a self-defense course in lieu of boxing. The requirement for women changed over the years into a comparable combatives class. West Point made the historic decision to integrate the boxing requirement in the summer of 2016, conducting a deliberate review of risk-management policies and procedures. Existing Army doctrine, however, provided limited guidance.

Safety First

The primary concern with gender integration of boxing is that women appear to experience concussions at a greater rate than men. This may be a result of physiological differences between men and women. On average, women also have less muscle mass than men of comparable weight. Boxing, like combatives, is a weight-category sport. Matching men and women according to weight may not adequately account for gender differences regarding striking force.

A detailed and multifaceted risk-management program is adhered to at West Point to ensure cadets meet boxing program objectives while providing a safe yet authentic environment. Before they can box, cadets must complete a preparticipation medical questionnaire, screened by medical providers. Whenever there is boxing training, medical personnel provide constant support and assistance.

Hand wraps are used to prevent hand fractures and wrist sprains, fitted mouthpieces are worn to guard against dental injuries, and headgear is worn to prevent cuts and abrasions to the face and forehead. Boxers must also wear gloves, which primarily serve to prevent hand injuries. Heavier gloves are also believed to reduce punch acceleration, limiting the amount of force a boxer can generate. Boxers therefore wear gloves according to body weight, with male cadets 175 pounds and less wearing 16-ounce gloves and male cadets over 175 pounds wearing 20-ounce

gloves. As a general policy, women wear 14-ounce gloves; however, instructors monitor females and increase the weight of the gloves for certain skilled boxers if warranted.

Cadets Closely Monitored

Aside from medical screening and protective equipment, instructors phase and control activities to further minimize injuries. Cadets are first taught punches in segments without an opponent. Segments are gradually reduced until cadets are performing full movements in formation or in mirrors. Once technique has improved to an acceptable level of proficiency, cadets find a partner within 10 pounds of their own weight for partner drills.

Instructors use verbal commands to control the volume of punches thrown, the defenses used, the tempo and, most importantly, the intensity. As cadets become more proficient, instructors increase the intensity and reduce the predictability of the drills. Trainers seek to maintain an inverse relationship between the intensity and the volume of punches, minimizing exposures at higher intensities. Finally, cadets may be pitted against each other in free sparring, which introduces the greatest amount of complexity. Although instructors closely supervise all sparring through issuing verbal commands, during free sparring, control is reduced.

Trainers continually assess cadet proficiency throughout instruction. Cadets are rated on a 1- to 5-point Likert-type scale, with a 1 designating an internationally competitive boxer and a 5 indicating a boxer so overcome with fear they can’t participate. Instructors then match cadets according to skill level, body weight (within 10 pounds), gender and aggression. This ensures that sparring contributes to attaining course objectives and limits injury risk. While conducting free sparring, cadets must box someone of the same gender. When conducting partner drills, however, cadets can work with a cadet of the opposite gender. Instructors continually monitor activities to ensure suitable matchups.

Another risk-mitigation policy that has proved effective at reducing concussion exposure is restriction of power punches to the head. Unlike a jab, a power punch utilizes weight transfer and rotation from the hips to increase the force of a strike. These punches are gradually introduced through instruction, allowing boxers time to develop defensive skills and timing. Power punches to the head are limited during free sparring, with cadets only permitted to throw one cross, one hook and one uppercut to the head per round. This policy serves to preserve the stimulus of perceived fear while minimizing the risk of injury.

A Budget for Boxing

Cost is always a factor when considering training objectives. Fortunately, most units possess Modern Army Combatives Program kits containing boxing gloves and headgear. A lack of punching bags is often cited as a concern. Bag work, however, is discouraged in favor of partner drills, as bags fail to improve defensive and offensive skills. A boxing ring is another cost issue, as many commercially available rings start at about $2,500. Free sparring should only occur in a regulation boxing ring for safety concerns, however, many benefits of boxing training can be gained through partner drills alone. A boxing ring may not be necessary to initially introduce and integrate boxing training into a combatives program. Hand wraps and fitted mouthpieces should be individually purchased due to hygiene concerns, and are readily available for under $10.

Female cadets at the U.S. Military Academy box in class for a grade.

(Credit: U.S. Army/John Pellino)

All units can benefit from incorporating boxing-style training into their combatives program. Doing so will increase the ability of soldiers to control their fear in stressful situations and improve confidence, Warrior Ethos, resiliency and proficiency in hand-to-hand combative encounters.

When incorporating striking into combatives training, however, commanders must ensure there are qualified instructors and medical support. A deliberate risk-management process must also be enforced. If conducting striking training with

soldiers of both genders, policies must account for the physiological differences between men and women, ensuring the safety of participants while reaching training objectives.

Gender integration is not simply a movement to one standard; it requires deliberate thought and constant evaluation. When done properly, striking can and should be incorporated into a unit's training program, increasing the combat readiness and lethality of our Army.

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* * *

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Maj. Alex Bedard *is a boxing instructor at the U.S. Military Academy, West Point, N.Y.*

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Maj. Robert "Pete" Peterson *is executive officer for the 2nd Battalion, 19th Infantry Regiment, 198th Infantry Training Brigade, Fort Benning, Ga.*

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Ray "Coach" Barone *is director of boxing at West Point. A retired field artillery officer, he has served in the boxing program at West Point for over 20 years.*

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EXHIBIT 14

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Ministry of Defence

Our Reference: FOI2014/02442

Jessica Key

Email: request-225421-9c8ef97b@whatdotheyknow.com

12 September 2014

Dear Ms Key

Thank you for your email dated 17 August 2014 requesting the following information:

Please provide a copy of your Policy for the Recruitment and Management of Transsexual Personnel in the Armed Forces.

Please also provide a copy of any other policy relating to transgender or transsexual personnel in the Armed Forces.

Please find attached the Defence Instructions and Notices internal MOD publication titled "Policy for the Recruitment and Management of Transsexual Personnel in the Armed Forces". The document is released in full, apart from the names of three Ministry of Defence named individuals, which have been redacted under section 40(2) of the FOI Act, on pages one and nine. There is no other policy advice related to transgender or transsexual personnel in the Armed Forces.

If you are not satisfied with this response or you wish to complain about any aspect of the handling of your request, then you should contact me in the first instance. If informal resolution is not possible and you are still dissatisfied then you may apply for an independent internal review by contacting the Information Rights Compliance team, 1st Floor, MOD Main Building, Whitehall, SW1A 2HB (e-mail CIO-FOI-IR@mod.uk). Please note that any request for an internal review must be made within 40 working days of the date on which the attempt to reach informal resolution has come to an end.

If you remain dissatisfied following an internal review, you may take your complaint to the Information Commissioner under the provisions of Section 50 of the Freedom of Information Act. Please note that the Information Commissioner will not investigate your case until the MOD internal review process has been completed. Further details of the role and powers of the Information Commissioner can be found on the Commissioner's website, http://www.ico.gov.uk.

Yours sincerely,

Defence Personnel Secretariat

DEFENCE INSTRUCTIONS AND NOTICES

(Not to be communicated to anyone outside HM Service without authority)

Title:	Policy for the Recruitment and Management of Transsexual Personnel in the Armed Forces
Audience:	Transsexual Service Personnel and all Service personnel and civilian staff who manage Service personnel
Applies:	Immediately
Expires:	When rescinded or replaced
Reference:	**2009DIN01-007**
Released:	January 2009
Channel:	01 - Personnel
Content:	Policy for the Recruitment and Management of Transsexual Personnel in the Armed Forces
Sponsor:	SPPol SC-EO
Contact:	[redacted], SPPol SC-EO2 (9) 6218 9620 (020 7218 9620) email: caroline.reynolds450@mod.uk

POLICY FOR THE RECRUITMENT AND MANAGEMENT OF TRANSSEXUAL PERSONNEL IN THE ARMED FORCES

Index:

POLICY FOR THE RECRUITMENT AND MANAGEMENT OF TRANSSEXUAL PERSONNEL IN THE ARMED FORCES

INTRODUCTION

1. This document sets out the Armed Forces' policy on the recruitment and management of transsexual personnel and provides general information on transsexualism and the process of gender reassignment. Its purpose is to provide guidance to serving personnel, Commanding Officers and Line Managers on how the relevant law applies, including the statutory duty to have due regard to the need to eliminate discrimination and harassment on the grounds of gender reassignment and the issues relating to the recruitment and management of transsexual people in the Armed Forces.

2. The incidence of transsexualism in the general population is comparatively low and it is unlikely that Commanding Officers and Line Managers will encounter many transsexual people in the course of their duties. It is important however that they are aware of the Armed Forces' policy on the recruitment and management of transsexual people and gender reassignment and understand what they must do, should the situation arise.

3. **Definition of Transsexualism.** Transsexual people have a deep conviction that their gender identity does not match their appearance and/or anatomy. The incongruity between identity and body can be so strong that individuals wish to present themselves in the opposite (also referred to as acquired) gender. This is a widely recognised medical condition variously referred to as gender dysphoria, gender identity disorder or transsexualism. It is a strong desire to live in the opposite gender to that in which a person has been registered at birth and be accepted in all respects as a member of that gender. Transsexualism is not a symptom of another medical condition.

4. Recognising that someone has gender dysphoria may not be straightforward. An individual who has gender dysphoria may show symptoms similar to those of a stress or anxiety related condition. In addition, people who have gender related issues are used to concealing them,

especially from authority figures. Service personnel who consider themselves to be transsexual are likely to have been through a turbulent and emotional period of coming to terms with their suspected gender identity. Sensitive and sympathetic handling of the individual is therefore essential. Any individual who declares him or herself to be a transsexual is to be offered the appropriate level of care and support whilst he or she considers, or pursues, gender reassignment.

5. It should be noted that gender identity and sexual orientation are two distinctly different issues and they should not be confused. Nor should transsexualism be confused with cross-dressing. (See Annex A, Glossary of Terms). Cross-dressing is far more common than Transsexualism and a Service person who cross-dresses in private life is unlikely to undergo gender reassignment. It is not appropriate to treat a transsexual person at any time as belonging to a "third gender".

6. The process of adopting the opposite gender role is generally known as "transition" and is often accompanied by treatment that may include counselling, hormone therapy, reconstructive surgery and cosmetic treatment (such as electrolysis for hair removal). Some people elect not to undergo any form of medical treatment and simply live their life in their new gender role.

7. **Terminology.** A comprehensive glossary of relevant terminology is at Annex A. It should be noted that once a person has begun the process of transitioning he or she should be addressed using the personal pronouns (he, she, hers, his, etc) appropriate to the gender towards which he or she is transitioning. The continued deliberate use of pronouns relating to the previous gender identity might be construed as sexual harassment.

LEGAL OVERVIEW

8. The following paragraphs provide a brief overview of relevant legislation. It is not intended to be authoritative legal advice. Single Service legal advisers should be consulted for advice on specific cases.

9. **The Sex Discrimination Act 1975 (SDA 75).** The SDA outlaws any form of discrimination on the grounds of an individual's gender. The Armed Forces have an exemption from the Act in respect of actions taken for the purpose of ensuring combat effectiveness but otherwise must comply with the Act's provisions.

10. The SDA was extended by the Sex Discrimination (Gender Reassignment) Regulations 1999 to outlaw discrimination against transsexual people in the workplace, making it unlawful for an employer to discriminate against someone on the ground that he or she has undergone, is undergoing or intends to undergo gender reassignment, unless being of a particular gender is a genuine occupational qualification for a particular job or one of a limited number of genuine occupational qualifications which apply during the reassignment process is applicable.

11. **The Gender Recognition Act 2004 (GRA 2004).** The GRA 2004 provides transsexual people with legal recognition in their "acquired" gender. Legal recognition follows from the issue of a full Gender Recognition Certificate (GRC) in cases where the Gender Recognition Panel (GRP) (a body made up of judicially trained lawyers and doctors) is satisfied that the applicant has, or has had, gender dysphoria; has lived in the acquired gender throughout the preceding two years; and intends to continue to live in the acquired gender until death. An applicant for a GRC must also prove that he or she is 18 years old or more. It should be noted that medical treatment is not a requirement for the issue of a GRC. There are many implications for an individual who receives official recognition in his or her new gender. Individuals should therefore be advised to read the guidance produced by the GRP which will help them make informed decisions about whether they wish to apply for gender recognition. (Contact details for the GRP are at Annex E) There is no requirement for a transsexual Serviceperson to acquire a GRC. Transsexual personnel who choose not to apply for a GRC (or who are unable to qualify for a GRC) should be treated the same as an individual who does have a GRC with regard to protection from discrimination.

12. **Payment of fees for applying to the GRP for a GRC.** When the GRP carries out work connected with an application for a GRC the applicant may have to pay a one-off fee. Service personnel applying for a GRC are responsible for paying any fee themselves. The maximum fee for applying for a GRC is currently £140. By law, certain applicants are eligible for a reduced fee or are exempt from paying altogether. Further details on the rules relating to the payment of a fee for a GRC are available from the GRP.

13. **Effect of acquiring a GRC on marriage or a civil partnership.** An applicant for a GRC needs to be unmarried for a "full", rather than an interim, certificate to be issued. This is because marriage is not permitted between two members of the same legally-recognised gender. This means that a married transsexual person's marriage must: end before he or she applies for a GRC; or end after an interim GRC has been issued; or end (with, perhaps, a child custody order and a maintenance order) but then be continued as a civil partnership once a GRC is issued. If the Service person does not get a GRC the marriage will continue to be valid. A transsexual person must not be in a UK civil partnership to receive a full GRC as a civil partnership may only be formed between people of the same gender in law.

14. Legal recognition has the effect that, for example, a male-to-female transsexual person is recognised as a woman for all purposes in law. Upon the issue of a full GRC, the person assumes all legal rights of their new gender, including the right to marry someone of the opposite gender to their acquired gender, or to form a civil partnership with someone of the same gender, and to retire and receive state pension at the age appropriate to the acquired gender.

15. **The annulment or dissolution process.** If an applicant for a GRC satisfies all the criteria for legal recognition but remains married he or she will receive an interim GRC. This may be used as evidence if either member of

the couple chooses to end their marriage on the basis that an interim GRC has been issued to a party to the marriage. In England, Wales and Northern Ireland the marriage may be annulled on this ground. In Scotland, a decree of divorce may be granted on this ground. Divorce proceedings must commence within six months of the date of issue of the interim GRC certificate. Further information about annulment or dissolution is available from the GRP.

16. **Civil Partnerships.** Couples who have ended their marriage in order for one partner to gain recognition in the acquired gender are able to register as civil partners of each other, under the Civil Partnership Act 2004 and thereby regain legal status for their relationship. Individuals who wish to enter into a Civil Partnership and who are successful in their application for a GRC are able to take advantage of a streamlined process whereby they can dissolve their marriage and register a Civil Partnership on the same day. The same process is available for people who form Civil Partnerships and subsequently transition. This allows them to transfer to marriage using a similar process.

17. If an individual has children, legal recognition in his or her acquired gender will not affect their legal status as the father or mother of the child or children. The individual's rights and responsibilities as a parent will be unaffected and the birth certificate(s) of the child or children will not be altered. As part of the annulment or dissolution process of the marriage a statement of the arrangements being made for the children after the marriage has been annulled should be included with the petition.

18. **Birth Certificate.** Birth certificates are legal documents and an individual may be required to produce one for a number of reasons. However, prior to legal recognition, a transsexual person's birth certificate states the original gender. For individuals whose application for a GRC is successful and whose birth was registered in the United Kingdom, the GRP will notify the relevant Registrar General of the issue of a full GRC.

19. The Registrar General will write to the individual and, where possible, will offer him or her options for the type of birth certificate available in the acquired gender. The Registrar General will also send the individual a draft of the information to be recorded. On receipt of a full GRC the Registrar General will send the individual a draft of the information to be recorded in the GRC to clarify what the entry will look like and to resolve any queries before the registration goes ahead. The draft will contain all the details about date and place of birth and parentage that are included in the original birth record, together with the individual's new name (or, if preferred the birth surname where this is different from the surname on the GRC) and the acquired gender as notified by the GRP.

20. If the individual's birth was registered in England or Wales prior to 1 April 1969, he or she will be sent two drafts, one in the pre-1969 landscape format (no surname) and one in the post-1969 portrait format. Guidance is provided to help the individual to decide which format to choose. Individuals

who choose the post-1969 portrait format will be asked to provide additional details for registration. The same will apply for Northern Ireland birth certificates issued before and after 1973, when the format changed. If the birth was registered in Scotland, the format of the certificate will match that of the original birth certificate, except that it will show the individual's new name and acquired gender.

21. On receipt of confirmation that the draft certificate is correct, together with any additional registration details provided by the individual, the Registrar General will create a new record in the Gender Recognition Register (GRR). The purpose of the GRR is simply to create a new record from which the Registrar General may produce a birth certificate. It is not intended as a record of all known transsexual people, nor does it record address details or any information which could be used to locate an individual. The GRR is not open to search by the public. One free copy of the short birth certificate will be sent to the individual. Any additional full birth certificates will need to be purchased by the individual at their own cost. The original birth certificate will however still exist and the individual will be able to obtain original birth certificates at any time.

22. **Right to privacy – prohibition of disclosure of "Protected Information".** Section 22 of the Gender Recognition Act establishes a right to privacy for the transsexual person in that it is a criminal offence for a person to disclose information that he or she has acquired in an official capacity about an individual's application for a GRC or about the gender history of an applicant. It is important to note that the liability under section 22 is a personal liability and it is a criminal offence. If someone is convicted of this offence they could be subjected to a fine of up to £5,000 and would incur a criminal record. Such information is "protected information". The term "official capacity" includes functions such as a member of the Armed Forces, the Civil Service, a constable, an employer or prospective employer, or a person acting in the course of business or the supply of professional services.

23. Once a transsexual person has a GRC, if someone whose duties gave access to that person's personal data disclosed that the person was born a different gender to the one in which they now live, an offence would be committed, subject to various exemptions, some of which are listed below. Section 22(4)(b) of the Act permits disclosure where the individual "has agreed to disclosure of the information" and, if such consent is forthcoming, can be used for HR purposes. Under section 22(4)(c) of the Act the prohibition on disclosure only extends to those people who know or believe that a GRC has been issued. However, if the holder of a GRC chooses to inform his or her respective Service Personnel Centre (SPC) that a GRC is held, apart from the specified exceptions set out below, an offence would be committed if the SPC disclosed the individual's gender history without his or her specific consent. It should be noted that the holder of a GRC is not obliged to inform their employer that one is held.

24. **Exceptions to the prohibition of disclosure of information.** The Gender Recognition Act contains a series of exceptions in section 22(4) that allow "protected information" to be disclosed for valid public policy reasons. A right to privacy does not mean absolute secrecy. There may be some situations in which a transsexual person will be required by law or necessity to prove a link between their current legal gender and their former one. There are also certain circumstances where disclosure of protected information does not constitute an offence. These include: disclosure for the purposes of prevention or investigation of crime; for the purposes of processing a claim for pensions and benefits; for religious purposes, eg whether it is permissible to officiate at or permit the marriage of the person to whom the information relates; for medical purposes in an emergency; disclosure by or on behalf of a credit reference agency; and disclosure for purposes in relation to insolvency or bankruptcy. In addition, it is not an offence to disclose "protected information" where it does not enable the person to be identified or where the individual to whom the information relates consents to the disclosure.

25. **The Data Protection Act (DPA) (1998).** Section 1 of the DPA defines "personal data", to which this act applies. Any personal data that relates to transsexualism and gender reassignment is "sensitive personal data." Under the DPA there are specific requirements attached to the recording, management and disclosure of sensitive personal data. In cases of doubt, further information and advice about the DPA should be sought from DG Info-AccessPol8 on telephone number 020 721 80509 (Mil Tel 9621 80509).

26. **Freedom of Information Requests.** Requests for Information made under the Freedom of Information Act 2000 (FOIA 2000) seeking information about an individual's gender history should be handled with care in order to avoid the inadvertent disclosure of protected information. Where an application is made under the FOIA 2000 for information that is "protected information" under the Gender Recognition Act, that information will be exempt from disclosure under section 44(1)(a) of FOIA in that the disclosure is prohibited by another law. The duty to confirm or deny under FOIA is excluded if compliance with that duty would involve disclosing protected information. The exemption at section 40 of FOIA may also apply, if the information requested is not prohibited under the GRA, but does fall within the definition of personal data under the DPA. Further advice about the FOIA is available from DG Info-AcessPol 8 (see 25 para above).

27. Requests for information on how many individuals serving in the Armed Forces have undergone or are undergoing gender reassignment should be answered with statistical data only. This means that the number of individuals should be rounded to the nearest 10 prior to release and no names or any other personal information should be disclosed.

28. **Criminal Records Bureau (CRB) Checks.** Special procedures apply for transsexual personnel who are required to go through the CRB checking process. Details of these procedures are available from designated points of contact at CRB Liverpool, Disclosure Scotland and Access NI. The points of contact are:

CRB
[redacted]
1st Floor South
Criminal Records Bureau
PO Box 165
Liverpool
L69 3JD
Tel: 0151 676 1452 (Monday to Friday 0900-1700)
Email: info@crb.gsi.gov.uk

Disclosure Scotland
[redacted]
Disclosure Scotland
PO Box 250
Glasgow
G51 1YU
Tel: 0141 585 8332

AccessNI
The Operations Manager
AccessNI
Brooklyn
65 Knock Road
Belfast
BT5 6LE
Tel: (helpline) 02890 259100

29. When a transsexual Serviceperson receives the forms for CRB checking he or she should contact the designated person in the relevant organisation (see above) and inform them of the application in advance of the form being sent. This enables a "flag" to be raised so that when the application form is received by CRB, Disclosure Scotland or AccessNI it is diverted to the designated specialist for processing. The CRB form should be completed using the individual's current name rather than any previous identity and once the ID check has been completed the form should be processed in the usual way. The DVA will forward it to the relevant CRB organisation, where it will be dealt with by the designated specialist.

30. **The Equality Act 2006 and Gender Equality Duty.** The Equality Act amends the SDA 1975 with effect from 6 April 2007 to place a statutory duty on all public authorities, when carrying out their functions to have due regard to the need:

a. to eliminate unlawful discrimination and harassment;

b. to promote equality of opportunity between men and women.

The Gender Equality Duty includes a duty to pay due regard to the elimination of discrimination and harassment of transsexual personnel.

31. **Section 19 of the GRA 2004 - exemptions concerning participation in competitive sport.** Section 19 of the GRA 2004 relates to sport. The Act does not require persons responsible for regulating participation of competitors in sporting events to permit transsexual people to compete in their acquired gender in all circumstances. In certain circumstances transsexual people may be restricted or prohibited from doing so to ensure fair competition or the safety of other competitors. This exemption only covers those participating in the sport as competitors and cannot be applied to people participating as non-competitors such as referees or line judges. Similarly, the exemption cannot be applied to those involved in or connected with the sport such as managers, coaches, spectators, supporters, or sports-ground staff.

32. Service clubs or organisations that organise, or are involved with, competitive sporting events should be aware of and follow the relevant sports national governing body policy on competition and consider whether it is necessary to exclude a transsexual person from competitive events on the basis of fair competition or safety. Further guidance for sporting bodies on transsexual people and sport has been promulgated by the Sports Division of the Department for Culture, Media and Sport (DCMS). Details are available from www.uksport.gov.uk.

33. **Discrimination and harassment on the grounds of gender reassignment.** Discrimination on the grounds of gender reassignment is defined in terms of comparative treatment of the transsexual person and that of "other persons" for whom gender reassignment grounds do not exist. This means treating a transsexual person less favourably than you treat (or would treat) someone else who is not undergoing gender reassignment (or contemplating it, etc). Harassment of an individual on the grounds of gender reassignment, either by their line management or by other Service personnel, is a form of unlawful discrimination. Such discrimination should be dealt with in the same way as harassment against any other Service person, for example on the basis of their sex or race. It is MoD policy that it is the right of each and every member of the Armed Forces to work in an environment which is free from harassment, intimidation and bullying and to expect to be treated with dignity and respect. Details of how to make, respond to and deal with complaints of harassment are set out in JSP 763, the MOD Harassment Complaints Procedure.

34. Some examples of discrimination on the grounds of gender reassignment may include:

a. Refusing to associate with or ignoring someone because they are transsexual;

b. Refusing to address the person in their acquired gender or to use their new name;

c. Probing into the person's private life and relationships;

d. Spreading malicious gossip about that person;

e. Failing to maintain confidentialty of information about a person's transsexual status;

f. Indefinite refusal to allow use of sanitary facilities appropriate to their acquired gender after a reasonable transition period;

g. Treating that person less favourably than others in regard to sickness or other absences.

h. Refusing to let people participate in sport with members of their acquired gender, subject to the guidance in paras 31 and 32.

35. **Roles closed to women.** A male to female transsexual person who is undergoing, or has undergone, transition will be debarred from joining or continuing in roles in the Armed Forces which are closed to women. The roles are: the Royal Marines General Service (as Royal Marine Commandos); the Submarine Service; the Diving branch; the Household Cavalry and Royal Armoured Corps; the Infantry and the Royal Air Force Regiment. This is in line with the general policy on women in the Armed Forces. A female-to-male transsexual person will not be debarred from joining these specialisations, subject to fulfilling the physical entry requirements.

36. **Leaving the Services on the grounds of Transsexualism.** There is no automatic right to leave the Armed Forces on the grounds of being a transsexual person. A transsexual person who no longer wishes to serve in the Armed Forces should apply for discharge in accordance with normal procedures.

APPLICATIONS TO JOIN THE ARMED FORCES FROM TRANSSEXUAL PEOPLE

37. Potential recruits may reveal that they are transsexual or be found to be undergoing, or to have completed treatment, at the initial medical examination. Applications to join the Armed Forces from transsexual people should be processed in the same way as any other application. It would be unlawful to reject an applicant on the grounds that he or she is a transsexual person. Transsexual people wishing to join the Armed Forces have to fulfil and achieve the same physical and mental entry requirements as any other eligible applicant. All applications should be dealt with on a case by case basis and each must be assessed on its own merit. Detailed guidance on recruitment medical standards and grading of transsexual candidates for recruitment is contained in JSP 346[1]. Following medical assessment a decision is to be made on the candidate's medical suitability to join the Armed Forces based on the guidance set out in JSP 346 and the single Services' own medical standards for entry.

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[1] PULHHEEMS: A Joint Service System of Medical Classification

38. **Requirement for confidentiality to protect information disclosed on applications/during interviews.** A potential recruit who has changed gender identity before applying to join the Armed Forces is under no obligation to inform the recruiting department dealing with their application of their gender history. Care should be taken to ensure that information contained in references from schools or colleges attended, previous employers or evidence of educational qualifications which discloses a previous name and gender identity is handled as "protected information". (See paragraphs 22 and 23)

MEDICAL ASSESSMENT OF TRANSSEXUAL APPLICANTS

39. **Medical grading of applicants who have completed transition and are living in their acquired gender.** Transsexual applicants who have completed transition (and, where appropriate, have been stabilised on hormone medication and fully recovered from surgery) may be graded P2, subject to fulfilling the normal medical standards according to the individual's legal gender.

40. **Psychiatric assessment of applicants.** As part of the screening process of applicants wishing to join the Armed Forces, all applicants are asked if they have a history of mental health problems or deliberate self-harm. Although transsexual people generally may have an increased risk of suicide, depression and self-harm, transsexual applicants should not automatically be referred to a Service Psychiatrist. The decision to refer a transsexual applicant for psychiatric assessment should be left to the single Service consultant responsible for recruitment and should be based on an assessment of whether the individual meets the guidelines relating to fitness to join the Armed Forces set out in JSP 346 and single Service medical standards for entry. Transsexual applicants with no history of mental health problems or deliberate self-harm who meet other fitness standards should be passed as being fit to join the Armed Forces.

41. **Medical grading of applicants who are in the transition phase.** Transition is often very challenging and transsexual people undergoing a long and difficult transition may feel isolated and distressed. For this reason recruitment into the Armed Forces and initial training may not be compatible with the supportive environment that is essential for transsexual people at this time. However, a transsexual person in gender transition may only need support for a comparatively short time before being able to resume a self-sufficient life. Applicants for recruitment who are not undergoing surgery or receiving hormonal treatment may be suitable for recruitment, subject to meeting the fitness standards required to join the Armed Forces.

42. **Medical grading of applicants who are undergoing hormone therapy.** Applicants who are receiving hormonal treatment may be graded P2 providing the dose of medication is stable, there are no significant side effects and the medication regime and its monitoring do not preclude world-wide deployment. (World-wide deployment may not be possible as some

medications have specific storage requirements which may be affected by deployment to cold or hot environments). In the very early stages of hormone treatment, it may be necessary to grade the individual P8 until treatment is stabilised, as with any other condition that is being treated or requires surgery at the time of application to join the Armed Forces.

43. **Medical grading of applicants who are undergoing surgical treatment.** Applicants who are about to undergo, or are still recovering from surgery to change the external appearance of their body into that of the acquired gender should be graded P8, as with any other condition that is being treated or requires surgery at the time of application, until they are fully recovered from the surgery.

MEDICAL GRADING OF SERVING TRANSSEXUAL PERSONNEL

44. **Initial actions for serving personnel wishing to undergo gender transition.** As already stated at para 3 above, transsexualism is a medical condition and a serving Service person who gives notification of wishing to undergo gender transition to the Chain of Command should be referred to their Medical Officer for an initial clinical assessment and onward referral as appropriate. Following clinical assessment and confirmation of gender dysphoria, future actions should be discussed between the relevant medical authorities (with the individual's full and informed consent), personnel management staffs and the chain of command. Each case should be considered on its own merits. The placing of a transsexual person into a reduced Medical Employment Standard (MES) (which may particularly become necessary when drug or surgical treatment is started or in progress) may restrict his or her postings within the Service and some form of assignment restriction may be necessary. It would however be unlawful to restrict assignment of an individual purely on the grounds of transsexualism. The transsexual person does not lose the right to stay with his or her existing unit if he or she wishes to remain (subject to the exception set out in paragraph 35 relating to roles closed to women and any medical considerations).

45. Once a diagnosis of gender dysphoria has been confirmed by a psychiatrist or psychologist, it will be necessary to allocate a Medical Category appropriate to the stage of transition and the treatment being undertaken, commensurate with safety considerations for the individual. Downgrading to P7, UK only, no sea service may be required to protect the individual from deployment or posting away from sources of support and treatment and to ensure availability to attend appointments. However, downgrading may not be required in all cases, especially where the individual elects not to undergo gender reassignment surgery.

46. The proposed medical grading should be discussed with the individual by medical staff in order to ensure that they understand the process of medical grading, and the reasons for it, and that they have no concerns about it.

47. **Medical grading of serving transsexual personnel not wishing to undergo treatment with hormones or surgery.** Serving personnel with gender dysphoria who do not wish to undergo hormone treatment or surgery may remain P2 unless the opinion of a Service psychiatrist, occupational physician or psychologist advises otherwise.

48. **Medical grading of serving transsexual personnel who undergo hormone treatment or surgery.** Serving personnel with gender dysphoria who choose to undergo hormone treatment or surgery will require medical downgrading (probably P7, UK only, no sea service) until the hormone treatment is stabilised or until the treatment no longer precludes deployment overseas and/or the recovery from surgery is completed. Deployment overseas may be precluded as some medications prescribed to transsexual people have specific storage requirements which may not be available in cold or hot environments.

49. **Medical grading of Service personnel who have completed transition and who are living in their acquired gender.** Transsexual Service personnel who have completed transition (and where appropriate have been stabilised on hormone medication and have fully recovered from surgery) may be graded P2, subject to fulfilling normal medical standards according to their legal gender.

50. Service personnel who retain a reduced MES for a significant period of time may need to be permanently graded or invalided. Permanent grading will be undertaken in accordance with single Service medical boarding procedures. A decision to recommend medical discharge (P8) should normally only be made by a consultant in occupational medicine, in accordance with HM Treasury recommendations on ill-health retirement. Transsexual personnel are treated no differently in this respect.

51. **Cost of treatment associated with hormone therapy and/or surgery.** Medication (eg hormonal treatment) prescribed by a Service or MOD doctor is paid for from the MOD budget, in the same way as for any other medical condition. The cost of some surgical and other specialist treatment for transsexual personnel is provided by the National Health Service (NHS), however corrective surgery is normally provided privately at the individual's expense. This is no different to any other medical condition.

52. **Male to female transsexual people in roles closed to women.** In the case of a male to female transsexual person, once the transition process starts she will no longer be able to serve in roles which are closed to women (see paragraph 35). Legal advice should be sought before any decision to transfer the individual to another post is made, especially if no suitable post can be found for her, requiring her to be discharged from the Service.

FITNESS TESTING AND TRANSSEXUAL PERSONNEL

53. Physical fitness is a fundamental requirement for all members of the Armed Forces and personnel are required to take fitness tests at regular intervals to meet both single-Service 'general fitness' requirements and, for some trades and arms, physical tests specific to that post. Where the test is set to measure fitness for a specific task, trade or arm the standard set will be absolute. This requires all personnel in that trade or arm to be able to pass the test at a single standard irrespective of age or gender. In this instance all personnel whether male, female or transgender will have to pass this single standard to remain eligible for service in that trade or arm.

54. Conversely, tests of 'general fitness' are there to ensure that individuals have the physical fitness attributes to cope with general non-specific physical demands such as prolonged working, stressful situations and arduous environments. The ability to cope with these situations is enhanced by undertaking regular physical exercise and thus 'general fitness' tests standards are set to both encourage and measure an individual's adherence to regular physical exercise. To account for physiological differences in absolute fitness standards between males and females, tests of 'general fitness' must, and do, set appropriate standards relative to the gender (and age) of those taking the test.

55. The point at which an individual is considered to have completed gender transition may vary from individual to individual, depending on medical treatment and other factors, thus each case should be considered on an individual basis. While there is an expectation that, in principle, transsexual personnel will meet the 'general fitness' standards of their acquired gender once transition has been completed there may, on rare occasions, be female to male transsexual personnel who cannot achieve the 'male' standard in a 'general fitness' test. A female to male Serviceperson who is unable to pass the required fitness test (of their acquired gender) should be referred for a medical assessment. In these circumstances it would be entirely consistent with the rationale for setting 'general fitness' standards for an appropriate standard to be applied to such individuals on a case by case basis.

56. One potential consequence of repeated failure to achieve the single-Service 'general fitness' standard is administrative discharge. There is nothing in this guidance on transgender fitness testing that alters this and thus, once an appropriate standard has been agreed, failure to attain it should result in the same sanction as would be applied to any other Service person.

THE PROCESS OF GENDER REASSIGNMENT OR TRANSITION

57. The term gender reassignment or transition refers to the process that a person goes through to present themselves permanently in their acquired gender. This usually includes a regime of specialist psychiatric evaluation, hormone treatment, real-life experiences and sometimes reconstructive surgery. The following table sets out the 5 stages in the process of changing gender through which transsexual personnel generally go, although it must be stressed that they will not all wish, or be able, to go through any, or all 5,

stages. An individual's MES should be reviewed at every stage of the reassignment process.

Gender Realisation	The individual realises that he or she is a transsexual person and will be medically diagnosed as such.
Social Reassignment (Transition)	The individual dresses and lives in their new gender role and is treated as being of the gender with which they identify. The individual is required to live and work in their new gender role for a period of one year prior to any irreversible surgical intervention.
Medical Treatment/Hormonal Reassignment	Medical treatment may include counselling and psychotherapy, hormones and anti-androgens, electrolysis and speech therapy. Hormone treatment is taken to change, gradually, the individual's body shape, appearance and behaviour. Hormone therapy is normally required for the rest of the individual's life.
Surgical Reassignment	The individual undergoes surgery and acquires physical characteristics appropriate to the acquired gender. Surgical treatment may include: genital surgery, breast augmentation or removal, re-shaping of the waist, plastic surgery to the nose and facial bones, reduction of the external appearance of larynx and modification of the vocal chords. Surgical procedures may be carried out over a number of years.
Post Operative	The individual returns to a normal routine in his or her new identity.

58. As the transition process from initial diagnosis of gender dysphoria to surgical reassignment is lengthy (possibly up to 3 years), careful and sensitive management of the individual's assignment and domestic and accommodation requirements will be needed.

59. **Agreement of transition programme.** To assist a transsexual person to complete his or her transition successfully it is useful for the individual to agree with their line management and other Service authorities an action plan for managing the process of transition. It is important to remember that the precise content and timescale for this process will be different in each individual case and could vary significantly and will depend on the circumstances of the individual. Key elements of the process include:

a. whether the individual wishes to stay in their current post or be assigned, although assignment will not be automatic, unless the

individual fails to meet the medical standard of the post or roles closed to women[2];

b. the expected timescale of the medical and surgical procedures;

c. the amount of time off required for medical appointments, treatments and surgical procedures;

d. the expected point or phase of change of name, personal details and social gender;

e. whether the individual wishes to inform their Line Manager and colleagues personally, or would prefer this to be done for them, and whether training or briefing of colleagues will be necessary;

f. what amendments will need to be made to records and systems;

g. agreeing a procedure for changing to the uniform of the acquired gender;

h. make arrangements for the individual to be moved to accommodation appropriate to his or her acquired gender;

j. an undertaking that details of the action plan and notes of any discussions or meetings should be kept strictly confidential.

60. A table setting out an example of a transition programme is at Annex B. It should be noted that each case will differ, depending on the circumstances and preferences of the individual involved. In addition to the need for sensitive management of the individual, the interests of the Service also need to be considered at an early stage. Early notification by the transitioning individual will help the Career Manager, the individual's Unit and any other individuals who may be affected to ensure that reduction in Operational Capability is minimised. Normally, a minimum of four weeks' notice will need to be given prior to the start of transition to enable the necessary administrative arrangements to be made/agreed.

61. **Informing colleagues.** Agreement between line management and the individual is imperative before communication and disclosure of the impending gender identity transition. How this is done depends not only on the individual's wishes but also on the size and structure of the unit or organisation where the individual is serving. In a small unit informing all personnel together may be the best approach. In a large unit or organisation it may be unnecessary to inform colleagues who have no direct contact with the individual. Sufficient detail should be provided to explain the facts in an appropriate manner and at a suitable level, without going into unnecessary personal or graphic detail.

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[2] See paragraph 35.

62. Units/organisations must manage the disclosure of information about an individual's transition carefully and sensitively to prevent sexual harassment or discrimination occurring. At the same time, care should be taken to ensure, as far as possible, that the individual's colleagues do not avoid contact with him or her because of concerns about saying the wrong thing. This can result in the individual feeling isolated. Education and awareness-raising are key here. Commanding Officers who have transsexual personnel within their units should seek advice from the relevant single Service Equality and Diversity staffs as early as possible about their management. The individual's right to privacy and the requirement for confidentiality should be clearly explained to peers and colleagues. Personnel should be informed that they have a personal liability under section 22 of the GRA not to disclose information obtained in an official capacity. (See paras 22 and 23).

ADMINISTRATIVE PROCEDURES – ACTIONS REQUIRED

63. **Change of Name.** This is done by Statutory Declaration and lodged with a civilian solicitor. A copy of the declaration is to accompany all applications to change records. All military records and documentation should use the new name from the date of the declaration. (A specimen name change proforma is at Annex C).

64. **Civilian Records.** The civilian records that will need to be changed to reflect the new name and gender status are listed below. Each application must be accompanied by a copy of the Change of Name statutory declaration/Deed Poll. It is the responsibility of the individual to ensure that the changes to the following civilian records are made on JPA/disclosed to personnel management authorities:

a. Tax code;

b. National Insurance card;

c. Passport;

d. National Health Card Number;

e. Bank details.

f. Driving Licence

g. European Health Insurance Card (EHIC)

65. **Service records and details.** The name on the Service records listed below is to be amended. All relevant data is to be transferred to the individual's new record:

a. Identity card;

b. Medical records;

c. Dental records;

d. Personal clothing record;

e. Internal records such as Personal file, JPA records, personal vehicle passes and other locally issued documentation;

f. Identity discs;

g. Railcard or coachcard;

h. Any other in-theatre documentation issued such as vehicle registration documents, ration cards, etc.

66. **Change of Service/Employee Numbers.** A transsexual person who has a gender-specific Service Number on JPA, which could identify him or her as having been originally of a different gender, may request a new gender free JPA Employee Number. Whilst it is assumed that personnel with gender-specific Service Numbers will wish to change to a gender-free JPA Employee Number, it is not mandatory to do so. A specific Business Process Guide on the process of changing a Service legacy number can be found on the SPVA JPA website. The Career Manager (CM) is to brief the individual on the administrative procedure that needs to be carried out to achieve a change and the effects it may have (it should be noted, for example, that the complete existing JPA record will need to be closed down and a new one created). Personnel should then decide and confirm with the CM whether they do, or do not, wish to change the number.

67. To preserve the individual's privacy the gender-specific legacy Service Number will not be held in the new record nor electronically linked by JPA Oracle to the new record with a JPA Employee Number. SPVA will however need to access the terminated record in order to make calculations on, for example, reckonable service and pensions.

68. **Issue of uniform relevant to the acquired gender.** Every effort should be made to ensure that the issue of new uniform relevant to a transsexual person's acquired gender is done in a single issue, especially for items of gender-specific kit. This avoids causing embarrassment or anxiety to the individual if repeated visits to uniform clothing stores are required. Arrangements and entitlements for the issue of uniform clothing to transsexual personnel are contained in the respective single-Service uniform regulations.

69. **Medal replacement and inscription policy for transsexual Service personnel who change their name and/or Service Number.** The Policy on the provision of replacement medals and inscription of medals for transsexual

Service personnel is set out in Annex D to Chapter 1 of JSP 761[3]. Serving transsexual members of the Armed Forces wishing to have their medals re-issued with their revised details should apply in writing to the MOD Medal Office, marking the envelope "Personal for the Officer in Charge", sending back their original medals and providing details of their new surname, initials and Service or Employee Number. Re-issued medals will be inscribed with the updated name, initials and Service or Employee Number, but will retain the rate or rank held by the individual at the time that the medal was originally awarded. Medals issued under these circumstances will not be marked "Replacement" and may be provided at public expense.

70. **Wearing of qualification badges.** Transsexual personnel who were entitled to wear qualification badges earned in their previous gender may continue to do so in their new gender if they so wish. They should however bear in mind that this may identify them as having previously been of a different gender.

71. **Notifying the Defence Vetting Agency (DVA).** The DVA is to be notified of a change of gender and name by the completion of MoD Form 1126, Change of Personal Circumstances Notification.

ARREST, LEGAL CUSTODY AND SEARCHING OF TRANSSEXUAL PERSONNEL

72. A transsexual Service person who is undergoing, or has undergone, transition should be treated according to their acquired gender if they are arrested, taken into legal custody or there is a requirement for them to be searched. If transition has not begun the individual should be treated as their birth gender. In cases where there is any question about the detained person's gender the individual should be asked in which gender they wish to be addressed.

73. **Detention in Custody.** While in custody a detained person may be placed in a cell or other secure room. Because of the potential vulnerability of transsexual personnel it is recommended that they should be detained in a cell on their own.

74. Any search involving the removal of garments other than an outer coat, jacket, gloves, headgear or footwear, or any other item concealing gender identity, may only be made by a police officer of the same gender as the acquired gender of the person being searched and may not be made in the presence of anyone of the opposite gender unless the person being searched specifically requests it. Particular sensitivity is required when searching someone who is in the transitional phase of gender re-assignment. At this time the individual will be presenting in their acquired gender and they will feel that they are a person of that gender. The views of all parties to the search should be fully taken into account before reaching any decision on who should conduct the search. The custody records should reflect all the actions taken by custody staff to comply with the detainee's requests.

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[3] Honours and Awards

75. If a person of the requested gender to conduct the search is not available, or is available but does not wish to carry out the search, and there is no other member of custody staff available to conduct the search, this must be fully recorded on the custody records.

76. Where a detainee has been granted a GRC they must, in every respect, be treated as a person of the acquired gender recognised by the Gender Recognition Panel. To do otherwise would be unlawful.

77. **Compulsory drug testing (CDT) procedures.** Tri-Service CDT procedures involving transsexual personnel are detailed in the Armed Forces Compulsory Drug Testing Team's SOP 141. Advice should be sought from the respective single-Service CDT team and/or single-Service Equality and Diversity Policy staff in the first instance.

ACCOMMODATION

78. **Single Living Accommodation (SLA).** The rules for transsexual personnel should be no different to those that apply to the gender group to which the transsexual person intends to transition and that apply to all individuals who live within SLA. The same applies to the use of ablutions. The following guidelines should be used.

79. Prior to social reassignment the individual should remain in his or her current living accommodation. Once social reassignment is planned and the process starts, the transsexual person should usually be accommodated in the accommodation of the gender to which he or she intends to transition. When the social reassignment stage has been reached (ie when the individual starts to dress and present in the clothes of their acquired gender) it will usually be appropriate for the transsexual person to use the toilet facilities of his or her acquired gender. Under no circumstances should a transsexual person be expected, after transitioning, to use the facilities of their former gender. It is unlawful to treat a transsexual person as though they are neither male nor female and to insist on him or her using separate facilities, such as an accessible toilet for disabled people, on a permanent basis. Each case should be individually managed in consultation between the individual, chain of command and medical officers.

80. **Service Family Accommodation (SFA).** Transsexual Servicemen or women who are married or in a civil partnership are therefore in PStatCat1 and retain their entitlement to SFA. However, if transsexual Servicemen or women who occupied SFA in PStatCat1 separate/divorce from their spouse or civil partner, they must vacate it within the timescale set out in JSP 464 (Tri-Service Accommodation Regulations), in the same way as any other Service person who is married or in a civil partnership. If the individual is in PStatCat2 (has parental responsibility for any children within the terms of the Children Act 1989) they will retain entitlement to SFA, or if they are PStatCat 3/4 then they retain eligibility for surplus SFA, in accordance with JSP 464.

MEDIA HANDLING

81. Instances of gender reassignment can in themselves attract attention from national and local press and when it relates to a member of the Armed Forces that interest can be intensified. If there is media interest in individual cases the rules governing contact with the Media and Communicating in Public, as set out in DIN 2008DIN03-020 should be adhered to. Early contact should also be made with the relevant single-Service Equality and Diversity Policy staff.

FURTHER INFORMATION

82. A list of support groups for transsexual people and sources of information is at Annex E.

DIVERSITY IMPACT ASSESSMENT

83. This policy does not discriminate on grounds of race, ethnic origin, religion, belief, sexual orientation or social background. Neither does it discriminate on grounds of gender, disability or age, insofar as the legislation applies to the Armed Forces. The Diversity Impact Assessment is held by the "Recruitment and Management of Transsexual Service Personnel in the Armed Forces" Policy sponsor.

ANNEX A

GLOSSARY OF TERMS

Acquired Gender Acquired Gender refers to the gender of a person who is in the process of getting, or has actually had their gender reassigned and/or legally recognised. This is not the gender that they were registered in at birth, but it is the gender in which they should be treated. It is possible for an individual to transition fully without medical treatment or surgical intervention.

Attributed Gender The gender that a person is taken to be by others. This is usually an immediate, unconscious categorisation of a person as being a man or woman, irrespective of their mode of dress.

Bisexuality Is where sexual attraction is to individuals of either or both genders. Bisexuality should not be confused with gender dysphoria.

Cross-Dressing Is the desire to adopt the clothes, appearance and behaviour normally associated with the opposite gender. This may be simple "dressing up" or "Dual Role Cross Dressing", which is the need to adopt the opposite role as fully as possible on a temporary or full-time basis. People who cross-dress in this way are sometimes knows as "Transgenderists". It should not be assumed that people who cross-dress are either gay or transsexual.

FTM A female to male transsexual person. A person who is changing, or has changed, gender role from female to male.

Gender The overwhelming majority of people have a gender that accords with their anatomical sexual presentation. Gender consists of two related aspects: gender identity, which is a person's internal perception and experience of their gender; and gender role, which is the way that the person lives in society and interacts with others, based on their gender identity.

Gender is less clearly defined than anatomical sexual presentation, and does not necessarily represent a simple "one or the other" choice. Some people have a gender identity that is neither clearly female nor clearly male.

For the purpose of the law, people can only be male or female.

Gender Dysphoria Gender dysphoria or gender identity disorder are the medical terms for the condition where a person who has been assigned one gender (usually at birth on the basis of their sex), identifies as belonging to another gender. It is a psychiatric term for what is often called transsexuality. A person with gender dysphoria may feel that they have a gender identity that is different from their anatomical sexual presentation. As a result, they may experience anxiety, uncertainty, or persistently uncomfortable feelings about their birth gender. Gender dysphoria should not be confused with sexual orientation.

Gender Identity A person's own psychological identification as male or female.

Gender Identity Disorder Another term for gender dysphoria or transsexualism. (See above)

Gender Reassignment /Transitioning A complex process which is undertaken over a long period of time under medical supervision for the purpose of reassigning a person's gender by changing physiological or other characteristics in relation to the acquired gender. This may include counselling, hormone treatment and (although not always) surgery involving, inter alia, chest and/or genital alteration. The process also includes legal adjustments such as changing the name and gender on legal documents.

Gender Recognition Gender Recognition is the process whereby a transsexual person may apply for legal recognition of his or her acquired gender. The process was established under the GRA.

Gender Recognition Certificate A full GRC shows that a person has satisfied the criteria for legal recognition in his or her acquired gender. The recipient of the certificate is considered, for all intents and purposes, as being of the gender listed on the certificate from that moment onward and not of their birth gender. The legal basis for creating a GRC is found in the GRA 2004.

An Interim GRC will be issued to a successful applicant if he or she is married or a civil partner at the time of the application. The interim certificate is issued to allow the applicant and his or her spouse/civil partner to end their marriage/civil partnership easily. It has no legal significance beyond this use. When the marriage/civil partnership is ended, a full GRC will be issued to the successful applicant.

Gender Recognition Panel A Gender Recognition Panel considers applications for gender recognition. The panels are ordinarily made up of legal and medical members who assess whether the legal and medical criteria for legal recognition are met. If the applicant is successful, the panel will issue a full or an interim GRC.

Legal Recognition Legal recognition means that in the eyes of the law a person is seen to be of his or her acquired gender, as opposed to the gender that was registered on that person's birth record when he or she was born.

MTF Male to female transsexual person. A person who is changing, or has changed, gender role from male to female.

Post-Operative Stage This is when an individual has undergone surgery and now presents some, or all, of the anatomical sexual characteristics relevant to their acquired gender.

Real Life Experience This is the phase of gender reassignment during which the individual must live and work in his or her acquired gender before certain medical procedures will be carried out.

Sexual Orientation An orientation towards persons of the same sex (lesbians or gay men) or an orientation towards a person of the opposite sex (heterosexual) or an orientation towards persons of the same sex and opposite sex (bisexual). Sexual orientation is not to be confused with Transsexualism.

Trans A generic term generally used by those who identify themselves as transgender, transsexual or transvestite. The term should only be used as an adjective.

Transgender An umbrella term for people whose gender identity and/or gender expression differs from their birth gender. This term should only be used as an adjective; that is individuals should be referred to as "transgender people", not "transgenders".

Transsexualism Another term for gender dysphoria or gender identity disorder. Transsexualism is to be preferred to the term transsexuality.

Transsexual Men Transsexual men are people who were registered at birth as female (or a girl) but now present to the world as male. **Transsexual women** were registered at birth as male (or a boy) but now present as female.

Transitional Period When a transsexual person decides to live fully in their preferred gender. They must do so for two years to be able to apply for a GRC. Normally during this time they will receive counselling, medication and, if they so wish, prepare for surgery (this can then also be known as the "pre-operative stage" or the "real life experience").

Transsexual Person For the purposes of this policy, the term transsexual is used to mean a person who intends to undergo, is undergoing or has in the past undergone gender reassignment (which may or may not involve hormone therapy or surgery). The term "transsexual" should be used as an adjective, not a noun, ie individuals should be referred to as "transsexual people" rather than "transsexuals".

Transvestite The clinical name for a cross-dresser. A person who dresses in the clothing of the opposite gender. Generally, transvestites do not wish to alter their body and do not necessarily experience gender dysphoria.

ANNEX B

Example of a Transition Programme

Timescale	Action Required
This column to be completed on an individual basis as agreed between the individual and his or her CO and Medical Officer	The individual confirms the transition plan in consultation with his or her CO and Medical Officer. Early consultation with respective single-Service Equality and Diversity Policy staff. SPC informed of the situation.
	CO discusses transition phase with Senior Executives on a "need to know" basis. Confidentiality must be maintained. Potential issues of social reassignment identified, eg domestic and assignment requirements. Chain of Command, in consultation with the individual draws up a plan for informing Unit of impending commencement of transition period. This should cover the medical and social aspects of the transition process and should include a plan for verbal and written briefings for Unit authorities and colleagues. SPC briefs the individual about amending Service details and records and civilian documentation. Provide the individual with a list giving details of records requiring amendment. (See Annex D) Establish and maintain close liaison with the relevant single-Service Equality and Diversity Policy staffs, the individual's Career Manager (SPC) and the individual's Unit Equality and Diversity Adviser (EDA). Individual's Medical Officer contacts the relevant Career Manager to initiate process for allocation of new Employee Number in JPA.
	Appropriate supply authority demands temperate scale clothing relative to the individual's acquired gender. Advice of individual's Medical Officer is to be sought before the individual starts duty in uniform. For practical reasons it may be appropriate for the individual to work in civilian clothes for an interim period. The decision to authorise the wearing of uniform should be made on a case-by-case basis. All administration for change of records initiated. Close liaison with the Career Manager /SPVA(G) will be necessary to avoid any rejection of system records. The SPVA JPA website includes a specific Transsexual Business Process Guide that needs to be consulted at an early stage to ensure a successful and timely update of records. Take action to ensure that other records/documents are amended (as per Annex D)

If necessary, move the individual into single accommodation, appropriate to his/her acquired gender prior to commencing any period of leave.
Individual section/department briefings given (as agreed above). Potential problem areas addressed by chain of command, with remedial action taken where necessary.
The individual reports for duty in his/her acquired gender. It will be important for line management to monitor the situation and take remedial action during the early stages of the Transition Period to ensure that the social reassignment programme progresses smoothly, for all personnel.

ANNEX C

SPECIMEN NAME CHANGE PROFORMA

I, JOAN ALICE SMITH of insert address a British subject DO SOLEMNLY AND SINCERELY DECLARE as follows:

1. I absolutely and entirely renounce and abandon the use of my former forenames of JOHN ALAN and adopt and determine to take and use from the date hereof the forenames of JOAN ALICE in substitution for my former forenames of JOHN ALAN

2. I shall at all times hereafter in all records deeds documents and other writings and in all actions and proceedings as well as in all dealings and transactions and on all occasions whatsoever use and subscribe the forenames of JOAN ALICE to the intent that I may hereafter be called known or distinguished not by the former name of JOHN ALAN but only by the name JOAN ALICE SMITH

3. I authorise and require all persons at all times to designate describe and address me by the adopted name of JOAN ALICE SMITH

AND I MAKE this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the Statutory Declarations Act 1835.

DECLARED at)
)
In the county of (insert) this day)
)
Of)

Before me,

Commissioner for Oaths/Solicitor

ANNEX D

Exemplar List of Records Requiring Amendment or Organisations to be Informed

The following lists may be used as an aide-mémoire and check list to assist transsexual personnel and their line management. It is not exhaustive.

SERVICE RECORD	**DATE CHANGED/ OR ORGANISATION INFORMED**
Employee Number (RN and Army only) Identity Card	
Medical Records (including DMICP)	
Dental Records	
Security Clearance records (via DVA) Personal Clothing Record	
Personal File	
Locally Issued documentation eg vehicle passes	
Identity Discs	
Railcard or Coachcard	
In-theatre documentation, eg vehicle registration documents, ration cards, etc	

CIVILIAN RECORD	**DATE CHANGED/ OR ORGANISATION INFORMED**
Tax code	
National Insurance Number (An individual who is successful in obtaining a full GRC is legally obliged to inform HM Revenue and Customs (HMRC) so that National Insurance records can be amended. Failure to do so may make the individual liable to prosecution. To make things easier, if an individual is successful in obtaining a GRC the Gender Recognition Panel will inform the HMRC on their behalf. To enable the GRP to do this the individual will need to supply them with the correct National Insurance number and a statement of consent.	
Passport	

National Health Service Card

European Health Insurance Card (EHIC)
Bank Details – including credit/debit cards and building society savings accounts, mortgage, share certificates, etc

Driving Licence (It is a legal requirement to inform the DVLA of any name change)

Vehicle Registration Documents

Electoral Registration (personal, post, proxy)
Insurance policies – personal, motor, life assurance

Will (an individual's will may need to be amended if entitlements/legacies under it are affected by the gender change)

ANNEX E

Advice or Support Groups for Transsexual People and Sources of Information

Single Service Equality and Diversity Policy staffs
Details of single-Service equality and diversity staffs can be found on Service intranet sites or by contacting a Unit Equality and Diversity Adviser (EDA).

A:GENDER
A:gender is the support network for staff in government departments and agencies who have changed or need to change permanently their perceived gender, or who identify as intersex. a:gender also acts in an advisory capacity to HR departments across the Civil Service and Cabinet Office.

a:gender	or:	a:gender
1st Floor		Grey 4
Seacole Building		The Exchange Brewery
2 Marsham Street		2 Bridge Street
London		Sheffield
SW1P 4DF		S3 8NS
Tel:	020 7035 4253	0114 207 4318
Mobile:	07786 096992	07876 145411
Email:	agender@homeoffice.gsi.gov.uk	
Website	www.csag.org.uk	

Depend
Depend is a voluntary organisation whose aim is to provide support, advice and information for anyone who knows, or is related to, a transsexual person in the UK.

Depend
BM Depend
London
WC1N 3XX

Email: infor@depend.org.uk
Website: www.depend.org.uk

FTM Network
The network is an informal and ad hoc self help group, open to all female to male transgender and transsexual people, or those exploring this aspect of their gender.

Website: www.ftm.org.uk

Inner Enigma
A charitable group which supports transsexual and transgender people.

Website: http://www.innerenigma.org.uk

The Gender Trust
The Gender Trust is a Registered Charity which helps adults throughout the United Kingdom who are Transsexual, Gender Dysphoric, Transgender or those whose lives are affected by gender identity issues.

The Gender Trust
PO Box 3192
Brighton
BN1 3WR

Tel: 01273 234024 (Mon-Fri 9am-5pm)
Email: info@gendertrust.org.uk
Website: http://www.gendertrust.org.uk/info@gendertrust.org.uk

Gender Recognition Panel
The Gender Recognition Panel was established under the Gender Recognition Act 2004 (GRA) to assess applications from transsexual people for legal recognition in their acquired gender. Application forms for Gender Recognition Certificates can be obtained from the Gender Recognition Panel's website.

The Gender Recognition Panel
PO Box 6987
Leicester
LE1 6ZX

Tel: 0845 355 5155
Email: GRP Enquiries
Website: www.grp.gov.uk

The Gender Identity Research and Education Society (GIRES)
GIRES is a registered charity that aims to promote education based on research into gender identity and intersex issues and supports the right of individuals to live according to their true gender identity, rather than one imposed upon them at birth.

GIRES
Melverley
The Warren
Ashstead
Surrey
KT21 2SP

Tel: 01372 801554
Website: www.gires.org.uk

Press for Change
UK civil rights campaign for transsexual and transgendered people. Their website provides information on legal issues and equal rights for trans-people.

Tel: 0161 432 1915
Email: www.pfc.org.uk/node/641#join – to join their mailing list
Website: www.pfc.org

Transgender Zone
A website for general information on trans issues; it also has information on trans-friendly places to go in London.

Transfabulous
A London based group providing support and entertainment for trans-people and their friends.

Website: http://www.transfabulous.co.uk

TransLondon
A London-based support group, that holds monthly meetings and also provides other resources for trans-people.

Website: http://www.translondon.org.uk/4.html
Email: TransLondon@hotmail.co.uk

EXHIBIT 15

DoD INSTRUCTION 1300.28

IN-SERVICE TRANSITION FOR TRANSGENDER SERVICE MEMBERS

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective:	October 1, 2016
Releasability:	Cleared for public release. Available on the DoD Issuances Website at http://www.dtic.mil/whs/directives.
Cancels:	Secretary of Defense Memorandum, "Transgender Service Members," July 28, 2015
Approved by:	Ashton Carter, Secretary of Defense

Purpose: This issuance:

- Establishes a construct by which transgender Service members may transition gender while serving.
- Enumerates prerequisites and prescribes procedures for changing a Service member's gender marker in the Defense Enrollment Eligibility Reporting System (DEERS).
- Specifies medical treatment provisions for Active Component (AC) and Reserve Component (RC) transgender Service members.
- Implements the policies and procedures in Directive-type Memorandum 16-005.

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY. This issuance applies to OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security, by agreement with that Department, and in all regards, except as to the requirement to submit issuances implementing this issuance to the Office of the Under Secretary of Defense for Personnel and Readiness 30 days in advance of publication in accordance with Paragraphs 2.1c and 2.2e), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

1.2. POLICY.

a. DoD and the Military Departments will institute policies to provide Service members a process by which, while serving, they may transition gender. These policies are premised on the conclusion that open service by transgender persons who are subject to the same standards and procedures as other members with regard to their medical fitness for duty, physical fitness, uniform and grooming standards, deployability, and retention, is consistent with military service and readiness.

b. The Military Departments and Services recognize a Service member's gender by the member's gender marker in the DEERS. Coincident with that gender marker, the Services apply, and the member is responsible to meet, all standards for uniforms and grooming; body composition assessment (BCA); physical readiness testing (PRT); Military Personnel Drug Abuse Testing Program (MPDATP) participation; and other military standards applied with consideration of the member's gender. As to facilities subject to regulation by the military, the Service member will use those berthing, bathroom, and shower facilities associated with the member's gender marker in DEERS.

c. Service members with a diagnosis from a military medical provider indicating that gender transition is medically necessary, will be provided medical care and treatment for the diagnosed medical condition. Recommendations of a military medical provider will address the severity of the Service member's medical condition and the urgency of any proposed medical treatment. Medical advice to commanders will be provided in a manner consistent with processes used for other medical conditions that may limit the Service member's performance of official duties.

d. Any medical care and treatment provided to an individual Service member in the process of gender transition will be provided in the same manner as other medical care and treatment. Nothing in this issuance will be construed to authorize a commander to deny medically necessary treatment to a Service member.

e. Any determination that a transgender Service member is non-deployable at any time will be consistent with established Military Department and Service standards, as applied to other Service members whose deployability is similarly affected in comparable circumstances unrelated to gender transition.

f. Commanders will assess expected impacts on mission and readiness after consideration of the advice of military medical providers and will address such impacts in accordance with this issuance. In applying the tools described in this issuance, a commander will not accommodate biases against transgender individuals. If a Service member is unable to meet standards or requires an exception to policy (ETP) during a period of gender transition, all applicable tools, including the tools described in this issuance, will be available to commanders to minimize impacts to the mission and unit readiness.

g. When the military medical provider determines that a Service member's gender transition is complete, and at a time approved by the commander in consultation with the transgender Service member, the member's gender marker will be changed in DEERS and the Service member will be recognized in the preferred gender.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R):

a. Updates existing DoD issuances, or promulgate new issuances, as appropriate, in accordance with the provisions of this issuance.

b. Expeditiously develops and promulgates education and training materials to provide relevant, useful information for transgender Service members, commanders, military medical providers, and the force.

c. Ensures that the text of proposed revisions to existing Military Department and Service regulations, policies, and guidance, and of any proposed new Military Department and Service issuance, is consistent with this issuance.

d. Issues guidance to the Military Departments, establishing the prerequisites and procedures for changing a Service member's gender marker in DEERS.

2.2. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD (USCG). The Secretaries of the Military Departments and the Commandant, USCG:

a. Adhere to all provisions of this issuance.

b. Administer their respective programs, and update existing Military Department regulations, policies, and guidance, or promulgate new issuances, as appropriate, in accordance with the provisions of this issuance.

c. Establish a Service Central Coordination Cell (SCCC) to provide multi-disciplinary (e.g., medical, legal, military personnel management) expert advice and assistance to commanders with regard to service by transgender Service members and gender transition in the military and to assist commanders in the execution of DoD, Military Department, and Service policies and procedures.

d. Educate their AC and RC forces to ensure appropriate understanding of the policies and procedures pertaining to gender transition in the military.

e. Submit to the USD(P&R) the text of any proposed revision to existing Military Department and Service regulations, policies, and guidance, and of any proposed new issuance, not later than 30 days in advance of the proposed publication date.

f. Ensure the protection of personally identifiable information (PII) and personal privacy considerations in the implementation of this issuance and Military Department and Service regulations, policies, and guidance.

g. Implement processes for the assessment and oversight of compliance with DoD, Military Department, and Service policies and procedures applicable to service by transgender persons, in accordance with Paragraph 3.8 of this issuance.

SECTION 3: GENDER TRANSITION

3.1. SPECIAL MILITARY CONSIDERATIONS. Gender transition while serving in the military presents unique challenges associated with addressing the needs of the Service member in a manner consistent with military mission and readiness. Where possible, gender transition should be conducted such that a Service member would meet all applicable standards and be available for duty in the birth gender prior to a change in the member's gender marker in DEERS and would meet all applicable standards and be available for duty in the preferred gender after the change in gender marker. Recognizing, however, that every transition is unique, the policies and procedures set forth herein provide flexibility to the Military Departments, Services, and commanders, in addressing transitions that may or may not follow this construct. These policies and procedures are applicable, in whole or in relevant part, to those Service members who intend to begin transition, are beginning transition, who already may have started transition, and who have completed gender transition and are stable in their preferred gender.

a. Medical.

(1) In accordance with DoD Instructions (DoDIs) 6025.19 and 1215.13, all Service members have a responsibility to maintain their health and fitness, meet individual medical readiness requirements, and report to their chains of command any medical (including mental health) and health issue that may affect their readiness to deploy or fitness to continue serving in an active status.

(2) Each Service member in the AC or in the Selected Reserve will, as a condition of continued participation in military service, report significant health information to their chain of command. Service members who have or have had a medical condition that may limit their performance of official duties, must consult with a military medical provider concerning their diagnosis and proposed treatment, and must notify their commanders.

(3) As in the case of other health issues, when a Service member receives a diagnosis from a military medical provider indicating that gender transition is medically necessary, the member's notification to the commander must identify all medically necessary care and treatment that is part of the Service member's medical treatment plan and a projected schedule for such treatment, including an estimated date for a change in the member's gender marker in DEERS.

b. Gender Transition in the Military. Gender transition begins when a Service member receives a diagnosis from a military medical provider indicating that gender transition is medically necessary, and concludes when the Service member's gender marker in DEERS is changed and the member is recognized in the preferred gender. At that point, the Service member will be responsible for meeting all applicable military standards in the preferred gender, and as to facilities subject to regulation by the military, will use those berthing, bathroom, and shower facilities associated with the preferred gender.

c. Continuity of Medical Care. A military medical provider may determine certain medical care and treatment to be medically necessary, even after a Service member's gender marker is

changed in DEERS (e.g., cross-sex hormone therapy). A gender marker change does not preclude such care and treatment.

d. Living in Preferred Gender. Real Life Experience (RLE) is the phase in the gender transition process during which the individual commences living socially in the gender role consistent with their preferred gender. Although in civilian life this phase is generally categorized by living and working full-time in the preferred gender, consistent application of military standards will normally require that RLE occur in an off-duty status and away from the Service member's place of duty, prior to the change of a gender marker in DEERS.

e. DEERS. The Military Departments and Services recognize a Service member's gender by the member's gender marker in DEERS. Coincident with that gender marker, the Services apply, and the member is responsible to meet, all standards for uniforms and grooming; BCA; PRT; MPDATP participation; and other military standards applied with consideration of the member's gender. As to facilities subject to regulation by the military, the Service member will use those berthing, bathroom, and shower facilities associated with the member's gender marker in DEERS.

f. Military Readiness. Unique to military service, the commander is responsible and accountable for the overall readiness of his or her command. The commander is also responsible for the collective morale and welfare and good order and discipline of the unit, the command climate, and for ensuring that all members of the command are treated with dignity and respect. When a commander receives any request from a Service member that entails a period of non-availability for duty (e.g., necessary medical treatment, ordinary leave, emergency leave, temporary duty, other approved absence), the commander must consider the individual need associated with the request and the needs of the command, in making a decision on that request.

3.2. ROLES AND RESPONSIBILITIES. The individual Service member, the military medical provider, the commander, and each of the Military Departments have crucial roles and responsibilities in the process of gender transition in the military.

a. Service Member's Role.

(1) Secure a medical diagnosis from a military medical provider.

(2) Notify the commander of a diagnosis indicating that gender transition is medically necessary, and identify all medically necessary treatment that is part of the member's medical treatment plan and a projected schedule for such treatment, including an estimated date for a change in the member's gender marker in DEERS, as set forth in Paragraph 3.1.a.

(3) Notify the commander of any change to the medical treatment plan, the projected schedule for **such** treatment, or the estimated date on which the member's gender marker would be changed in DEERS.

b. Military Medical Provider's Role.

(1) Establish the member's medical diagnosis, recommend medically necessary care and treatment, and, in consultation with the Service member, develop a medical treatment plan associated with the Service member's gender transition, as set forth in Paragraph 3.1.a, for submission to the commander.

(2) In accordance with established military medical practices, advise the commander on the medical diagnosis applicable to the Service member, including the provider's assessment of the medically necessary care and treatment, the urgency of the proposed care and treatment, the likely impact of the care and treatment on the individual's readiness and deployability, and the scope of the human and functional support network needed to support the individual.

(3) In consultation with the Service member, formally advise the commander when the Service member's gender transition is complete, and recommend to the commander a time at which the member's gender marker may be changed in DEERS.

(4) Provide the Service member with medically necessary care and treatment after the member's gender marker has been changed in DEERS.

c. Commander's Role.

(1) Review a Service member's request to transition gender. Ensure, as appropriate, a transition process that:

(a) Complies with DoD, Military Department, and Service regulations, policies, and guidance.

(b) Considers the individual facts and circumstances presented by the Service member.

(c) Ensures military readiness by minimizing impacts to the mission (including deployment, operational, training, and exercise schedules, and critical skills availability), as well as to the morale and welfare, and good order and discipline of the unit.

(d) Is consistent with the medical treatment plan.

(e) Incorporates consideration of other factors, as appropriate.

(2) Coordinate with the military medical provider regarding any medical care or treatment provided to the Service member, and any medical issues that arise in the course of a Service member's gender transition.

(3) Consult with the SCCC with regard to service by transgender Service members and gender transition in the military, the execution of DoD, Military Department, and Service policies and procedures, and assessment of the means and timing of any proposed medical care or treatment.

d. Role of the Military Department and the USCG.

(1) Establish policies and procedures in accordance with this issuance, outlining the actions a commander may take to minimize impacts to the mission and ensure continued unit readiness in the event that a transitioning individual is unable to meet standards or requires an ETP during a period of gender transition. Such policies and procedures may address the means and timing of transition, procedures for responding to a request for an ETP prior to the change of a Service member's gender marker in DEERS, appropriate duty statuses, and tools for addressing any inability to serve throughout the gender transition process. Any such actions available to the commander will consider and balance the needs of the individual and the needs of the command in a manner comparable to the actions available to the commander in addressing comparable Service member circumstances unrelated to gender transition. Such actions may include:

(a) Adjustments to the date on which the Service member's gender transition, or any component of the transition process, will commence.

(b) Advising the Service member of the availability of options for extended leave status or participation in other voluntary absence programs during the transition process.

(c) Arrangements for the transfer of the Service member to another organization, command, location, or duty status (e.g., Individual Ready Reserve), as appropriate, during the transition process.

(d) ETPs associated with changes in the member's physical appearance and body composition during gender transition, such as accommodations in the application of standards for uniforms and grooming, BCA, PRT, and MPDATP participation.

(e) Establishment of, or adjustment to, local policies on the use of berthing, bathroom, and shower facilities subject to regulation by the military, during the transition process.

(f) Referral for a determination of fitness in the disability evaluation system in accordance with DoDI 1332.18.

(g) Other actions, including the initiation of administrative or other proceedings, comparable to actions that could be initiated with regard to others whose ability to serve is similarly affected for reasons unrelated to gender transition.

(2) Establish policies and procedures, consistent with this issuance, whereby a Service member's gender marker will be changed in DEERS based on a determination by the military medical provider that the Service member's gender transition is complete; receipt of written approval from the commander, issued in consultation with the Service member; and production by the Service member of documentation indicating gender change. Such documentation is limited to:

(a) A certified true copy of a State birth certificate reflecting the Service member's preferred gender;

(b) A certified true copy of a court order reflecting the Service member's preferred gender; or

(c) A United States passport reflecting the member's preferred gender.

(3) When the Service member's gender marker in DEERS is changed:

(a) Apply uniform standards, grooming standards, BCA standards, PRT standards, MPDATP standards, and other standards applied with consideration of the member's gender, applicable to the Service member's gender as reflected in DEERS.

(b) As to facilities that are subject to regulation by the military, direct the use of berthing, bathroom, and shower facilities according to the Service member's gender marker as reflected in DEERS.

3.3. GENDER TRANSITION APPROVAL PROCESS.

a. A Service member on active duty, who receives a diagnosis from a military medical provider for which gender transition is medically necessary may, in consultation with the military medical provider and at the appropriate time, request that the commander approve:

(1) The timing of medical treatment associated with gender transition;

(2) An ETP associated with gender transition, consistent with Paragraph 3.2.d, and/or

(3) A change to the Service member's gender marker in DEERS.

b. The commander, informed by the recommendations of the military medical provider, the SCCC, and others, as appropriate, will respond to the request within a framework that ensures readiness by minimizing impacts to the mission (including deployment, operational, training, exercise schedules, and critical skills availability), as well as to the morale and welfare and good order and discipline of the command.

c. Consistent with applicable law, regulation, and policy, the commander will:

(1) Comply with the provisions of this issuance, and with Military Department and Service regulations, policies, and guidance, and consult with the SCCC.

(2) Promptly respond to any request for medical care, as identified by the military medical provider, and ensure that such care is provided consistent with applicable regulations.

(3) Respond to any request for medical treatment or an ETP associated with gender transition, as soon as practicable, but not later than, 90 days after receiving a request determined to be complete in accordance with the provisions of this issuance and Military Department and Service regulations, policies, and guidance. The response will be in writing; include notice of any actions taken by the commander in accordance with applicable regulations, policies, and guidance and the provisions of this issuance; and will be provided to both the Service member

and their military medical provider. A request that, upon review by the commander, is determined to be incomplete, will be returned to the Service member, with written notice of the deficiencies identified, as soon as practicable, but not later than 30 days after receipt.

(4) At any time prior to the change of the Service member's gender marker in DEERS, the commander may modify a previously approved approach to, or an ETP associated with, gender transition. A determination that modification is necessary and appropriate will be made in accordance with the procedures, and upon review and consideration of the factors set forth in Paragraph 3.2.c of this issuance. Notice of such modification will be provided to the Service member under procedures established by the Secretary of the Military Department concerned, and may include options as set forth in Paragraph 3.2.d.

(5) The commander will approve, in writing, the change of a Service member's gender marker in DEERS, subsequent to receipt of the recommendation of the military medical provider that the member's gender marker be changed and receipt of the requisite documentation from the Service member. Upon submission of the commander's written approval to the appropriate personnel servicing activity, the change in the Service member's gender marker will be entered in the database and transmitted to and updated in DEERS, under the authority, direction, and control of the Defense Manpower Data Center.

d. As authorized by Military Department and Service regulations, policies, and guidance implementing this issuance, a Service member may request review by a senior officer in the chain of command, of a subordinate commander's decision with regard to any request under this issuance and any subsequent modifications to that decision.

3.4. ADDITIONAL RC CONSIDERATIONS.

a. General. Excepting only those special considerations set forth below, RC personnel are subject to all policies and procedures applicable to AC Service members as set forth in this issuance and in Military Department and Service regulations, policies, and guidance implementing this issuance.

b. Gender transition approach. All RC Service members (except Selected Reserve full-time support personnel) identifying as transgender individuals, will submit to, and coordinate with their chain of command, evidence of a medical evaluation that includes a medical treatment plan. Selected Reserve full-time support personnel will follow the gender transition approval process set forth in Paragraph 3.3.

c. Medical treatment plans. A medical treatment plan established by a civilian medical provider will be subject to review and approval by a military medical provider.

d. Selected Reserve Drilling Member Participation. To the greatest extent possible, commanders and Service members will address periods of non-availability for any period of military duty, paid or unpaid, during the member's gender transition with a view to mitigating unsatisfactory participation. In accordance with DoDI 1215.13, such mitigation strategies may include:

(1) Rescheduled training.

(2) Authorized absences.

(3) Alternate training.

e. Delayed Training Program. Delayed Training Program personnel must be advised by recruiters and commanders of limitations resulting from being non-duty qualified. As appropriate, Service members in the Delayed Training Program may be subject to the provisions of Paragraph 3.5 of this issuance.

f. Split Option Training. When authorized by the Military Department concerned, Service members who elect to complete basic and specialty training over two non-consecutive periods may be subject to the provisions of Paragraph 3.5 of this issuance.

3.5. INITIAL ENTRY TRAINING AND CONSIDERATIONS ASSOCIATED WITH THE FIRST TERM OF SERVICE.

a. A blanket prohibition on gender transition during a Service member's first term of service is not permissible. However, the Department recognizes that the All-Volunteer Force readiness model is largely based on those newly accessed into the military being ready and available for multiple training and deployment cycles during their first term of service. This readiness model may be taken into consideration by a commander in evaluating a request for medical care or treatment or an ETP associated with gender transition during a Service member's first term of service. Any other facts and circumstances related to an individual Service member that impact that model will be considered by the commander as set forth in this issuance and implementing Military Department and Service regulations, policies, and guidance.

b. The following policies and procedures apply to Service members during the first term of service and will be applied to Service members with a diagnosis indicating that gender transition is medically necessary in the same manner, and to the same extent, as to Service members with other medical conditions that have a comparable impact on the member's ability to serve:

(1) A Service member is subject to separation in an entry-level status during the period of initial training (defined as 180 days per DoDI 1332.14) based on a medical condition that impairs the Service member's ability to complete such training.

(2) An individual participant is subject to separation from the Reserve Officers' Training Corps in accordance with DoDI 1215.08, or from a Service Academy in accordance with DoDI 1322.22, based on a medical condition that impairs the individual's ability to complete such training or to access into the Armed Forces, under the same terms and conditions applicable to participants in comparable circumstances not related to transgender persons or gender transition. As with all cadets or midshipmen who experience a medical condition while in the Reserve Officers' Training Corps Program or at a Service Academy, each situation is unique and will be evaluated based on its individual circumstances; however, the individual will be required

to meet medical accession standards as a prerequisite to graduation and appointment in the Armed Forces.

(3) A Service member is subject to administrative separation for a fraudulent or erroneous enlistment or induction when warranted and in accordance with DoDI 1332.14, based on any deliberate material misrepresentation, omission, or concealment of a fact, including a medical condition, that if known at the time of enlistment, induction, or entry into a period of military service, might have resulted in rejection.

(4) If a Service member requests non-urgent medical treatment or an ETP associated with gender transition during the first term of service, including during periods of initial entry training in excess of 180 days, the commander may give the factors set forth in Paragraph 3.5.a significant weight in considering and balancing the individual need associated with the request and the needs of the command, in determining when such treatment, or whether such ETP may commence in accordance with Paragraph 3.2.d.

3.6. PROTECTION OF PII AND PROTECTED HEALTH INFORMATION.

a. In accordance with DoDD 5400.11, in cases in which there is a need to collect, use, maintain, or disseminate PII in furtherance of this issuance or Military Department and Service regulations, policies, or guidance, the Military Departments and the USCG will protect against unwarranted invasions of personal privacy and the unauthorized disclosure of such PII. The Military Departments and the USCG will maintain such PII so as to protect individual's rights, consistent with federal law, regulation, and policy.

b. Disclosure of protected health information will be consistent with DoD 6025.18-R.

3.7. PERSONAL PRIVACY CONSIDERATIONS. A commander may employ reasonable accommodations to respect the privacy interests of Service members.

3.8. ASSESSMENT AND OVERSIGHT OF COMPLIANCE.

a. The Secretaries of the Military Departments and the Commandant, USCG, will implement processes for the assessment and oversight of compliance with DoD, Military Department, and Service policies and procedures applicable to service by transgender persons.

b. Beginning in 2018 and no less frequently than triennially thereafter, Secretaries of the Military Departments and the Commandant, USCG, will direct an Inspector General Special Inspection of compliance with this issuance and implementing Military Department or USCG regulations, policies, and guidance. The directing official will review the Report of Inspection for purposes of assessing and overseeing compliance; identifying compliance deficiencies, if any; timely initiating corrective action, as appropriate; and deriving best practices and lessons learned.

GLOSSARY

G.1. ACRONYMS.

AC	Active Component
BCA	body composition assessment
DEERS	Defense Enrollment Eligibility Reporting System
DoDI	DoD instruction
ETP	exception to policy
MPDATP	military personnel drug abuse testing program
PII	personally identifiable information
PRT	physical readiness testing
RLE	real life experience
RC	Reserve Component
SCCC	Service Central Coordination Cell
USCG	United States Coast Guard
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

G.2. DEFINITIONS. Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

cross-sex hormone therapy. The use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth. A common medical treatment associated with gender transition.

gender marker. Data element in DEERS that identifies a Service member's gender. A Service member is expected to adhere to all military standards associated with the member's gender marker in DEERS and use military berthing, bathroom, and shower facilities in accordance with the DEERS gender marker.

gender transition is complete. A Service member has completed the medical care identified or approved by a military medical provider in a documented medical treatment plan as necessary to achieve stability in the preferred gender.

gender transition process. Gender transition in the military begins when a Service member receives a diagnosis from a military medical provider indicating that the member's gender transition is medically necessary, and concludes when the Service member's gender marker in DEERS is changed and the member is recognized in the preferred gender.

human and functional support network. Support network for a Service member that may be informal (e.g., friends, family, co-workers, social media.) or formal (e.g., medical professionals, counselors, clergy).

medically necessary. Those health-care services or supplies necessary to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine.

non-urgent medical care. The care required to diagnose and treat problems that are not life or limb threatening or that do not require immediate attention.

preferred gender. The gender in which a transgender Service member will be recognized when that member's gender transition is complete and the member's gender marker in DEERS is changed.

RLE. The phase in the gender transition process during which the individual commences living socially in the gender role consistent with their preferred gender. RLE may or may not be preceded by the commencement of cross-sex hormone therapy, depending on the medical treatment associated with the individual Service member's gender transition. The RLE phase is also a necessary precursor to certain medical procedures, including gender transition surgery. RLE generally encompasses dressing in the new gender, as well as using preferred gender berthing, bathroom, and shower facilities.

SCCC. Service-level cell of experts created to provide multi-disciplinary (e.g., medical, legal) advice and assistance to commanders with regard to service by transgender Service members and gender transition in the military.

stable in the preferred gender. Medical care identified or approved by a military medical provider in a documented medical treatment plan is complete, no functional limitations or complications persist, and the individual is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning. Continuing medical care, including but not limited to cross-sex hormone therapy, may be required to maintain a state of stability.

transgender Service member. A Service member who has received a medical diagnosis indicating that gender transition is medically necessary, including any Service member who intends to begin transition, is undergoing transition, or has completed transition and is stable in the preferred gender.

transition. Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in another gender role; for others this means finding a gender role and expression that are most comfortable for them. Transition may or may not include feminization or masculinization of the body through cross-sex hormone therapy or other medical procedures. The nature and duration of transition are variable and individualized.

urgent medical care. The care needed to diagnose and treat serious or acute medical conditions that pose no immediate threat to life and health, but require medical attention within 24 hours.

REFERENCES

Directive-type Memorandum 16-005, "Military Service of Transgender Service Members," July 1, 2016

DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003

DoD Directive 5400.11, "DoD Privacy Program," October 29, 2014

DoD Instruction 1215.08, "Senior Reserve Officers' Training Corps (ROTC) Programs," June 26, 2006

DoD Instruction 1215.13, "Ready Reserve Member Participation Policy," May 5, 2015

DoD Instruction 1322.22, "Service Academies," September 24, 2015

DoD Instruction 1332.14, "Enlisted Administrative Separations," January 27, 2014, as amended

DoD Instruction 1332.18, "Disability Evaluation System (DES)," August 5, 2014

DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," June 9. 2014

EXHIBIT 16

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 2:17-cv-01297-MJP

DECLARATION OF ADMIRAL MICHAEL MULLEN IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Michael Mullen, declare as follows:

1. I am a retired Admiral of the United States Navy. From to 2007 to 2011, I served as the Chairman of the Joint Chiefs of Staff. In this capacity, I was the principal military advisor to Presidents George W. Bush and Barack Obama. I offer this declaration in my personal capacity and not as an expert witness.

PERSONAL BACKGROUND

2. I am a 1968 graduate from the United States Naval Academy in Annapolis. In 1985, I graduated from the Naval Postgraduate School in Monterey, California, with a Master of Science degree in Operations Research. In 1991, I completed the Harvard Business School Advanced Management Program.

3. I served over 43 years in the Navy. During my tenure, I served in the Bureau of Naval Personnel as Director, Chief of Planning and Provisions, Surface Officer Distribution and

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in the Office of the Secretary of Defense on the staff of the Director, Operational Test and Evaluation. I also served as Deputy Director and Director of Surface Warfare and as Deputy Chief of Naval Operations for Resources, Requirements, and Assessments. From August 2003 to October 2004, I was the Vice Chief of Naval Operations. As Commander, U.S. Naval Forces Europe and Allied Joint Force Naples, I had operational responsibility for NATO missions in the Balkans, Iraq, and the Mediterranean. I was also responsible for providing overall command, operational control, and coordination of Naval forces in Europe. I then became Chief of Naval Operations, a position included among the Joint Chiefs of Staff, under the direction of the Vice Chairman and Chairman.

4. In June 2007, then Defense Secretary Robert M. Gates announced his intention to advise President George W. Bush to nominate me to be Chairman of the Joint Chiefs of Staff. After receiving the nomination, the Senate confirmed me. On October 1, 2007, I was sworn in as the 17th Chairman of the Joint Chiefs of Staff ("Chairman"), becoming the highest-ranking officer in the United States Armed Forces. I became Chairman in the midst of the Global War on Terrorism and two wars.

5. My duties and functions as Chairman are set forth in Department of Defense Directive 5100.01. The Chairman is the senior ranking member of the Armed Forces and principal military adviser to the President, Secretary of Defense, the National Security Council (NSC), the Homeland Security Council (HSC), and the Secretary of Defense. My duties as Chairman included, among other things, reporting to the Secretary of Defense on the responsiveness and readiness of the military, advising the Secretary of Defense with regard to joint personnel matters such as requirements for command and control, promulgating publications to provide military guidance for joint activities of the Armed Forces, and developing policies and procedures for education and training of service members.

OPEN SERVICE BY TRANSGENDER SERVICE MEMBERS

6. I concur with Defense Secretary Ash Carter's July 2015 assessment that the Defense regulations regarding transgender service members "[were] outdated and [were] causing uncertainty that distracted commanders from our core missions." I closely followed Secretary

Carter's direction to Armed Services leadership to evaluate the implications of allowing transgender personnel to serve openly in the military and the Pentagon's ensuing evaluation.

7. My understanding is that the military conducted a thorough research and evaluation process on the issue of open service by transgender troops and concluded that inclusive policy for transgender troops promotes readiness. I agree with this conclusion and support Secretary Carter's June 2016 directive to end the ban on open service by transgender people.

8. To reverse this policy by implementing a ban on open service would go against the best interests of thousands of service members currently serving. As the Pentagon has pointed out, it may also deprive our military of trained and skilled service members and leave vacancies that may not be easy to fill. This would harm military readiness as well as morale. The military's prior considered judgment on this matter should not be disregarded and we should not breach the faith of service members who defend our freedoms, including those who are transgender.

PARALLELS TO END OF DON'T ASK, DON'T TELL

9. In 2008, pursuant to my duties as Chairman, I ordered my staff to conduct a study about the Don't Ask, Don't Tell ("DADT") policy and its ramifications to the force. This policy barred gay, lesbian, and bisexual individuals from serving openly in the military.

10. During his January 2010 State of the Union Address, President Obama reiterated his pledge to end DADT. A week later, I testified and endorsed the President's plan before members of the Senate Armed Services Committee.

11. Part of that plan, as adopted by Congress, required the Pentagon to study the effects of allowing open military service by gay men, lesbians, and bisexuals. That study, which was released in late November of 2010, concluded that allowing such open service would present minimal risk to military effectiveness. President Obama subsequently signed the repeal of DADT into law. On September 20, 2011, nine months after Secretary Leon Panetta, President Obama, and I certified to Congress that the military was ready to execute the new policy, DADT officially ended.

12. In my 2010 testimony to the Senate Armed Services Committee regarding DADT, referenced above, I stated, "It is my personal belief that allowing gays and lesbians to serve openly would be the right thing to do." I also testified that "no matter how I look at the issue, I cannot escape being troubled by the fact that we have in place a policy which forces young men and women to lie about who they are in order to defend their fellow citizens." This is still my opinion. Just as gay and lesbian soldiers should not have to lie about who they are to serve, nor should transgender soldiers.

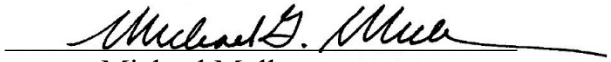
13. The now repealed DADT was problematic and flawed in similar ways as the ban on open service by transgender service members. Both DADT and the ban on open service by transgender individuals set apart a subset of brave women and men serving in uniform and treat them worse than other soldiers for no valid reason – and both policies potentially undermine military readiness.

14. When I led our armed forces under DADT, I saw firsthand the harm to readiness and morale when we fail to treat all service members according to the same standards. There are thousands of transgender Americans currently serving and there is no reason to single them out to exclude them or deny them the medical care that they require.

15. Moreover, I strongly believe that we should not return to the days of "forc[ing] young men and women to lie about who they are in order to defend their fellow citizens."

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: January 21, 2018



Michael Mullen

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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that all participants in the case are registered CM/ECF users and that service of the foregoing documents will be accomplished by the CM/ECF system on January 25, 2018.

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EXHIBIT 17

THE HILL

Navy, Marines chiefs say no mo issues with transgender troops

BY REBECCA KHEEL - 04/19/18 11:53 AM EDT

© Getty Images

The top officers of the Navy and Marines said Thursday that they have no evidence that unit morale and cohesion has been negatively affected by the open service of transgender individuals.

But the commandant of the Marines added that some commanders have raised issues about the medical needs of some transgender troops.

“I am not aware of any issues in those areas,” Marines Commandant Gen. Robert Neller said in response to a question from Sen. Kirsten Gillibrand (D-N.Y.) about unit morale amid service by transgender troops.

“The only issues I’ve heard of is in some cases, because of the medical requirements of some of these individuals, that there is a burden on the commands to handle all the medical stuff," he continued. "But discipline, cohesion of the force, no.”

Gillibrand asked Neller and Chief of Naval Operations Adm. John Richardson about the issue during a Senate Armed Services Committee hearing Thursday.

Last month, President Trump signed a memo banning most transgender people from serving in the military “except under certain limited circumstances.” The memo gave Defense Secretary James Mattis and Homeland Security Secretary Kirstjen Nielsen, who oversees the Coast Guard, “authority to implement any appropriate policies concerning military service by transgender individuals.”

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ADMINISTRATION — 3H 10M AGO

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— 4H 34M AGO

VIEW ALL

No new policy can go into effect immediately, as courts have issued preliminary injunctions that require the Pentagon to continue allowing open service while lawsuits work their way through the court system.

Trump's memo was signed in conjunction with the release of a report Mattis submitted to the president outlining his recommendations on how to handle transgender troops. Among the issues raised in the report was the potential of such individuals to disrupt unit morale.

In a Senate Armed Services Committee hearing last week, Army Chief of Staff Gen. Mark Milley told Gillibrand he has not heard of any issues with unit cohesion in the Army because of the open service of transgender troops.

On Thursday, Gillibrand asked Neller to elaborate on what he meant by the medical requirements of transgender troops being a "burden."

"For commanders, some of them have said, 'No, it's not a problem at all,'" Neller said. "Others have said that there is a lot of time where this individual is maybe or may not be available. So we're all about readiness. We're looking for deployability."

Neller also said he's met with four of the 27 Marines who have come out as transgender since their open service has been allowed, adding he "learned a lot" from the meetings.

"We had a very candid and frank conversation and I respect ... their desire to serve, and all of them to the best of my knowledge were ready and prepared to deploy," Neller said. "And as long as they can meet the standard of what their particular occupation was, then I think we'll move forward."

Richardson also told Gillibrand he was not aware of any issues with unit morale and cohesion.

"By virtue of being a Navy sailor, we treat every one of those sailors regardless with dignity and respect that is warranted by wearing the uniform of the United States Navy. By virtue of that approach, I am not aware of any issues," Richardson said.

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He added the service was applying lessons it learned from the integration of women into service aboard submarines.

"It's steady as she goes," Richardson said. "We're taking lessons from when we integrated women into the submarine force, and one of the pillars of that is to make sure there were really no differences highlighted in our approach to training those sailors. That program has gone very well. So maintaining that level playing field of a standards-based approach seems to be a key to success and that's the approach we're taking."

TAGS KIRSTEN GILLIBRAND KIRSTJEN NIELSEN JAMES MATTIS DONALD TRUMP TRANSGENDER LGBT TRANSGENDER MILITARY SERVICE NAVY MARINE CORPS

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