Exhibit 1

Memorandum from former Secretary of Defense Ash Carter titled “Transgender Service Members,”

dated July 28, 2015

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

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS

SUBJECT: Transgender Service Members

JUL 28 2015

Effective as of July 13, 2015, no Service member shall be involuntarily separated or denied reenlistment or continuation of active or reserve service on the basis of their gender identity, without the personal approval of the Under Secretary of Defense for Personnel and Readiness. This approval authority may not be further delegated.

The Under Secretary of Defense for Personnel and Readiness will chair a working group composed of senior representatives from each of the Military Departments, Joint Staff, and relevant components from the Office of the Secretary of Defense to formulate policy options for the DoD regarding the military service of transgender Service members. The working group will start with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective, practical impediments are identified, and shall present its recommendations to me within 180 days. Pending the issuance of DoD-wide policy following the submission of the working group's report, any interim guidance issued by the Military Departments will be coordinated with, and subject to the prior personal approval of, the Under Secretary of Defense for Personnel and Readiness. If questions relating to the service of transgender members arise, the Military Departments should address them to the Under Secretary of Defense for Personnel and Readiness.

Ash Carter

cc:
DepSecDef
CJCS
USDs
DoD, GC
ASD(LA)
ATSD(PA)

Exhibit 2

Declaration of Stephanie A. Barna,

dated June 1, 2018

JANE DOE 2, et al.,	)	
	)	
Plaintiffs,	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
	)	
DONALD TRUMP, et al.,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF STEPHANIE A. BARNA

I, Stephanie A. Barna, do hereby declare as follows:

1. I am the Acting Assistant Secretary of Defense (Manpower and Reserve Affairs), serving as the Senior Policy Advisor to the Under Secretary of Defense for Personnel and Readiness, within the Department of Defense (DoD). In this capacity, I advise the Under Secretary on matters related to Total Force management, including military readiness and training, and military personnel requirements. I have served in this capacity since February 2018. From June 2014 through the date of this memorandum, I served first as the Acting Assistant Secretary of Defense (Readiness and Force Management) and subsequently performed the duties of the Assistant Secretary of Defense (Manpower and Reserve Affairs), the duties of the Principal Deputy Under Secretary of Defense for Personnel and Readiness, and the duties of the Under Secretary of Defense for Personnel and Readiness. In these roles, I served as principal advisor to the Secretary of Defense and/or the Under Secretary of Defense (Personnel and Readiness) on all personnel matters, including civilian and military personnel policies, reserve affairs, Total Force Planning and Requirements, and diversity. I also served in senior leadership positions in the Department of the Army as a career senior executive, and retired from the U.S. Army Reserve in 2011 in the rank of Colonel.

2. In my current role, I have oversight responsibility for the drafting and implementation of policy concerning military service by transgender individuals.

3. In the exercise of my official duties, I have been made aware of this lawsuit and the related litigation involving DoD transgender service policy. The information in this declaration is based on my personal knowledge and on information made available to me in my official capacity.

4. On February 22, 2018, the Secretary of Defense, with the agreement of the Secretary of Homeland Security, sent the President a memorandum proposing a new policy regarding military service by transgender persons. The memorandum was accompanied by a 44-page report detailing the proposed policy and explaining the rationale for it. On March 23, 2018, the President issued a memorandum that revoked his August 2017 memorandum and any other directive he may have made on military service by transgender persons, thereby allowing the Secretaries of Defense and Homeland Security to implement their proposed policy.

5. The proposed policy includes an exemption for "transgender Service members who were diagnosed with gender dysphoria by a military medical provider after the effective date of the Carter policy, but before the effective date of any new policy." Report 43. Under the policy, these Service members "may continue to receive all medically necessary treatment, to change their gender marker in DEERS, and to serve in their preferred gender, even after the new policy commences." *Id.*

6. The Department included this exemption because of its commitment to honor the reasonable expectations of Service members "who were diagnosed with gender dysphoria and

either entered or remained in service following the announcement of the Carter policy and the court orders requiring transgender accession and retention" and because of the "substantial investment" it has made in them. *Id.* Consistent with these purposes, the Department will, if permitted to implement its proposed new policy, exempt any Service member who was diagnosed with gender dysphoria prior to the effective date of the Carter policy and has continued to serve and receive treatment pursuant to the Carter policy after it took effect. In addition, because the new policy is not yet in effect, at present the Department will exempt any current Service member who is diagnosed with gender dysphoria by a military medical provider before the effective date of the new policy.

Pursuant to 28 U.S.C. § 1746(2), I declare under the penalty of perjury that the foregoing is true and correct.

Executed on June 1, 2018

Stephanie A. Barna

STEPHANIE A. BARNA

Exhibit 3

DoD Instruction 6130.03 titled “Medical Standards for Appointment, Enlistment, or Induction into the Military Services,”

effective May 6, 2018

DoD INSTRUCTION 6130.03

MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION INTO THE MILITARY SERVICES

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective:	May 6, 2018
Releasability:	Cleared for public release. Available on the Directives Division Website at http://www.esd.whs.mil/DD/.
Reissues and Cancels:	DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
Approved by:	Robert L. Wilkie, Under Secretary of Defense for Personnel and Readiness

Purpose: This issuance, in accordance with the authority in DoD Directive 5124.02, establishes policy, assigns responsibilities, and prescribes procedures for physical and medical standards for appointment, enlistment, or induction into the Military Services. It was approved by Mr. Wilkie on March 30, 2018, and will take effect 30 days after publication on the Directives Division Website.

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This issuance applies to:

(1) 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 DoD.

(2) The Reserve Components, which include the Army and the Air National Guards of the United States, in accordance with Title 10, United States Code (U.S.C.).

(3) The United States Merchant Marine Academy in accordance with Section 310.56 of Title 46, Code of Federal Regulations.

b. The entities in Paragraphs 1.1.a.(1) through 1.1.a.(3) are referred to collectively in this issuance as the "DoD Components."

c. This issuance does not apply to any medical issue associated with gender dysphoria or gender transition; such medical accession standards are addressed in separate guidance. Any questions regarding such medical accessions standards or procedures should be directed to the Commander, U.S. Military Entrance Processing Command (USMEPCOM).

1.2. POLICY.

It is DoD policy to:

a. Use the guidance in this issuance for appointment, enlistment, or induction of personnel into the Military Services.

b. Use common medical standards for appointment, enlistment, or induction of personnel into the Military Services and eliminate inconsistencies and inequities in the DoD Components based on race, sex, or location of examination when applying these standards.

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

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

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

(3) Medically capable of satisfactorily completing required training and initial period of contracted service.

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

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

d. Allow applicants who do not meet the physical and medical standards in this issuance to be considered for a medical waiver.

1.3. INFORMATION COLLECTIONS. DD Form 2807-1, "Report of Medical History;" DD Form 2807-2, "Accessions Medical Prescreen Report;" DD Form 2808, "Report of Medical Examination;" and the supplemental health documents referred to in Paragraph 2.3.d. of this issuance have been assigned Office of Management and Budget control number 0704-0413 in accordance with the procedures in Volume 2 of DoD Manual 8910.01. The expiration date of this information collection is listed on the DoD Information Collections System at https://apps.sp.pentagon.mil/sites/dodiic/Pages/default.aspx.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R):

a. Ensures that the standards in Section 5 are implemented throughout the DoD Components.

b. Eliminates inconsistencies and inequities based on race, sex, or location of examination in DoD Component application of these standards.

c. Maintains and convenes the chartered Medical and Personnel Executive Steering Committee (MEDPERS).

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

a. Reviews, approves, and issues technical modifications to the standards in Section 5 to the Secretaries of the Military Departments.

b. Provides guidance to the DoD Medical Examination Review Board to implement the standards in Section 5.

2.3. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD. The Secretaries of the Military Departments and the Commandant, United States Coast Guard:

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

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

c. Ensure that accurate International Classification of Diseases 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.

d. Ensure that medical information for “Existed Prior to Service” discharges is provided to the USMEPCOM by Service training centers conducting basic military training. This information will include:

(1) A copy of the trainee’s medical discharge summary and related medical documents.

(2) Copies of DD Forms 2807-2, 2807-1, and 2808, including supplemental behavioral health screening documents.

(3) Consultation reports or other medical documentation used in the enlistment process and qualification decision.

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

2.4. SECRETARY OF THE NAVY. In addition to the responsibilities in Paragraph 2.3., the Secretary of the Navy will direct the medical processing for applicants seeking entry into the Military Services from Guam and environs while applying and uniformly implementing the standards contained within this issuance.

SECTION 3: MEDPERS

3.1. ORGANIZATION. The MEDPERS convenes at least twice a year under the joint guidance of the Deputy Assistant Secretary of Defense for Military Personnel Policy and the Deputy Assistant Secretary of Defense for Health Services Policy and Oversight and in accordance with the MEDPERS charter.

3.2. AGENDA. The MEDPERS:

a. Provides the Accession Medical Standards Working Group with guidance and oversight on setting standards for accession medical and physical processes.

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

c. Ensures medical and personnel community coordination when changing policies that affect each community and other relevant DoD Components.

SECTION 4: MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION

4.1. APPLICABILITY. The medical standards in Section 5 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 that predate the current enlistment and were not aggravated in the line of duty during the current enlistment, these standards apply to enlistees during the first 6 months of the current period of active duty.

c. Applicants for accession in the Reserve Components and federally recognized units or organizations of the National Guard. For medical conditions or defects that predate the original term of service and were not aggravated in the line of duty during such term of service, these standards apply during the applicant's initial period of active duty for training until their return to the Reserve Components.

d. Applicants for re-accession 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 the separation physical.

e. Applicants for the Service academies, Reserve Officer Training Corps, Uniformed Services University of the Health Sciences, and all other DoD Component special officer personnel procurement programs.

f. Cadets and midshipmen at the Service academies and students enrolled in Reserve Officer Training Corps scholarship programs applying for retention in their respective programs.

g. Individuals on the Temporary Disability Retired List who have been found fit when reevaluated by the Disability Evaluation System 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 the procedures in this issuance only for the conditions for which they were found fit on reevaluation by the Disability Evaluation System. Applicants must meet all other medical standards contained in this section with the exception of the medical condition for which they were placed on the Temporary Disability Retired List.

h. All individuals being inducted into the Military Services.

4.2. PROCEDURES.

a. Applicants for appointment, enlistment, or induction into the Military Services will:

(1) Fully disclose all medical history.

(2) Submit all medical documentation related to medical history as requested to the USMEPCOM and DoD Medical Examination Review Board, including the names of their medical insurer and past medical providers.

(3) Provide authorization for the DoD Components to request and obtain their medical records.

(a) Authorize the DoD to request medical or behavioral health data holders (e.g. healthcare providers, clinics, hospitals, insurance companies, pharmacy benefit managers, pharmacies, health information exchanges, and federal and State agencies) release complete transcripts of health data to the DoD medical authority for the processing of their application for military service.

(b) Authorize holders of their health data to report to the DoD whether any data they hold or have held about them has been amended or restricted.

(4) Acknowledge that information provided constitutes an official statement, and that any persons making false statements could face fines, penalties, and imprisonments pursuant to Section 1001 of Title 18, U.S.C. If the applicant is selected for enlistment, commission, or entrance into a commissioning program based on a false statement, the applicant can be tried by court-martial or meet an administrative board for discharge and could receive a less than honorable discharge.

b. The USMEPCOM and DoD Medical Examination Review Board will:

(1) Render medical qualification decisions by using standard medical terminology to describe a medical condition, rather than International Classification of Disease codes.

(2) Use coding to document personnel actions in order to collect information to enable research, analyses, and support for evidence-based medical standards.

c. The DoD Components:

(1) May initiate and request a medical waiver. Each DoD Component's waiver authority for medical conditions will make a determination based on all available information regarding the issue or condition, as well as the specific needs of the Military Service.

(2) Will specify any medical condition which causes a personnel action, such as separation, medical waiver, or assignment limitation, by utilizing standard medical terminology, the International Classification of Diseases, Current Procedural Terminology, or the Healthcare Common Procedure Coding System for data collection and analysis in support of evidence based standards.

SECTION 5: DISQUALIFYING CONDITIONS

5.1. MEDICAL STANDARDS. Unless otherwise stipulated, the conditions listed in this section 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 into general systems in Paragraphs 5.2. through 5.30.

5.2. HEAD.

a. Deformities of the skull, face, or mandible of a degree that may reasonably be expected to prevent the individual from properly wearing a protective mask or military headgear.

b. Loss, or absence of the bony substance of the skull 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 U.S. quarter coin.

5.3. EYES.

a. Lids.

(1) Current symptomatic blepharitis.

(2) Current blepharospasm.

(3) Current dacryocystitis, acute or chronic.

(4) Defect or deformity of the lids or other disorders affecting eyelid function, including ptosis, sufficient to interfere with vision, require head posturing, or impair protection of the eye from exposure.

(5) Current growths or tumors of the eyelid, other than small, non-progressive, asymptomatic, benign lesions.

b. Conjunctiva.

(1) Current acute or chronic conjunctivitis excluding seasonal allergic conjunctivitis.

(2) Current pterygium if condition encroaches on the cornea in excess of 3 millimeters (mm), is symptomatic, interferes with vision, or is progressive.

(3) History of pterygium recurrence after any prior surgical removal.

c. Cornea.

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

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

(3) Corneal refractive surgery performed with an excimer or femtosecond laser, including but not limited to photorefractive keratectomy, laser epithelial keratomileusis, laser-assisted in situ keratomileusis, and small incision lenticule extraction, 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) Within 180 days of accession medical examination.

(d) Complications, ongoing medications, ophthalmic solutions, or any other therapeutic interventions required beyond 180 days of procedure.

(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 either more than +/- 0.50 diopters difference for spherical vision or more than +/- 0.50 diopters for cylinder vision.

(4) Current or recurrent keratitis.

(5) History of herpes simplex virus keratitis.

(6) Current corneal neovascularization, unspecified, or corneal opacification from any cause that is progressive or reduces vision.

(7) Any history of uveitis or iridocyclitis.

d. Retina. Any history of any abnormality of the retina, choroid, or vitreous.

e. Optic Nerve.

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

(2) Any optic nerve anomaly.

f. Lens.

(1) Current aphakia, history of lens implant to include implantable collamer lens, or any history of dislocation of a lens.

(2) Any history of opacities of the lens, including cataract.

g. Ocular Mobility and Motility.

(1) Current or recurrent diplopia.

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

(3) Esotropia, exotropia, and hypertropia.

(4) History of restrictive ophthalmopathies.

h. Miscellaneous Defects and Diseases.

(1) History of abnormal visual fields.

(2) Absence of an eye.

(3) History of disorders of globe.

(4) Current unilateral or bilateral exophthalmoses.

(5) History of glaucoma, ocular hypertension, pre-glaucoma, or glaucoma suspect.

(6) Any abnormal pupillary reaction to light or accommodation.

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

(8) Current night blindness.

(9) History of intraocular foreign body, or current corneal foreign body.

(10) History of ocular tumors.

(11) History of any abnormality of the eye or adnexa, not specified in Paragraphs 5.3.h.(1)-(10), which threatens vision or visual function.

5.4. VISION.

a. Current distant visual acuity of any degree that does not correct with spectacle lenses to at least 20/40 in each eye.

b. For entrance into Service academies and officer programs, the individual DoD Components may set additional requirements. The DoD Components will determine special administrative criteria for assignment to certain specialties.

c. Current near visual acuity of any degree that does not correct to 20/40 in the better eye.

d. Current refractive error (hyperopia, myopia, astigmatism) in excess of -8.00 or +8.00 diopters spherical equivalent or astigmatism in excess of 3.00 diopters.

e. Any condition that specifically requires contact lenses for adequate correction of vision, such as corneal scars and opacities and irregular astigmatism.

f. Color vision requirements will be set by the individual DoD Components.

5.5. EARS.

a. Current defect that would require either recurrent evaluation or treatment or that may reasonably be expected to prevent or interfere with the proper wearing or use of military equipment (including hearing protection) to include atresia of the external ear or severe microtia, congenital or acquired stenosis, chronic otitis externa, or severe external ear deformity.

b. Any history of Ménière's Syndrome or other chronic diseases of the vestibular system.

c. History of any surgically implanted hearing device.

d. History of cholesteatoma.

e. History of any inner or middle ear surgery.

f. Current perforation of the tympanic membrane or history of surgery to correct perforation during the preceding 180 days.

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

5.6. HEARING.

a. Audiometric hearing levels are measured by audiometers calibrated to the standards in American National Standards Institute S3.6-2010 and will be used to test the hearing of all applicants.

b. Current hearing threshold level in either ear that exceeds:

(1) Pure tone at 500, 1000, and 2000 cycles per second for each ear of more than 25 decibels (dB) on the average with any individual level greater than 30 dB at those frequencies.

(2) Pure tone level more than 35 dB at 3000 cycles per second or 45 dB at 4000 cycles per second for each ear.

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

c. History of using hearing aids.

5.7. NOSE, SINUSES, MOUTH, AND LARYNX.

a. Current cleft lip or palate defects not satisfactorily repaired by surgery or that prevent drinking from a straw or that may reasonably be expected to interfere with using or wearing military equipment.

b. Current ulceration of oral mucosa or tongue, excluding aphthous ulcers.

c. Symptomatic vocal cord dysfunction to include but not limited to vocal cord paralysis, paradoxical vocal cord movement, spasmodic dysphonia, non-benign polyps, chronic hoarseness, or chronic laryngitis (lasting longer than 21 days). History of vocal cord dysfunction with respiratory symptoms or exercise intolerance.

d. Current olfactory deficit.

e. Recurrent, unexplained epistaxis requiring medical intervention within the last 2 years.

f. Current chronic sinusitis, current nasal polyp or polypoid mass(es) or history of sinus surgery within the last 2 years, excluding antralchoanal polyp or sinus mucosal retention cyst.

g. Current symptomatic perforation of nasal septum.

h. History of deformities, or conditions or anomalies of the upper alimentary tract, mouth, tongue, palate, throat, pharynx, larynx, and nose, that interfered with chewing, swallowing, speech, or breathing.

5.8. DENTAL.

a. Current diseases or pathology of the jaws or associated tissues that prevent the jaws' normal functioning. A minimum of 6 months healing time must elapse for any individual who completes surgical treatment of any maxillofacial pathology lesions.

b. Temporomandibular disorders or myofascial pain that has been symptomatic or required treatment within the last 12 months.

c. Current severe malocclusion, 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.

d. Eight or more grossly (visually) cavitated or carious teeth. 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 only if a civilian or military dentist or endodontist provides documentation that active endodontic treatment will be completed prior to being sworn to active duty.

e. Current orthodontic appliances (mounted or removable, e.g., Invisalign®) for continued active treatment unless:

(1) The appliance is permanent or removable retainer(s); or

(2) An orthodontist (civilian or military) provides documentation that:

(a) Active orthodontic treatment will be completed before being sworn in to active duty; or

(b) All orthodontic treatment will be completed before beginning active duty.

5.9. NECK.

a. Current symptomatic cervical ribs.

b. Current congenital mass, including cyst(s) of branchial cleft origin or those developing from the remnants of the thyroglossal duct or history of surgical correction, within 12 months.

c. Current contraction of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent that it may reasonably be expected to interfere with properly wearing a uniform or military equipment, or is so disfiguring as to reasonably be expected to interfere with or prevent satisfactorily performing military duty.

5.10. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM.

a. Any abnormal findings on imaging or other examination of body structure, such as the lungs, diaphragm, or other thoracic or abdominal organs, unless the findings have been evaluated and further surveillance or treatment is not required.

b. Current abscess of the lung or mediastinum.

c. Infectious pneumonia within the last 3 months.

d. History of recurrent (2 or more episodes within an 18 month period) infectious pneumonia after the 13th birthday.

e. History of airway hyper responsiveness including asthma, reactive airway disease, exercise-induced bronchospasm or asthmatic bronchitis, after the 13th birthday.

(1) Symptoms suggestive of airway hyper responsiveness include but are not limited to cough, wheeze, chest tightness, dyspnea or functional exercise limitations after the 13th birthday.

(2) History of prescription or use of medication (including but not limited to inhaled or oral corticosteroids, leukotriene receptor antagonists, or any beta agonists) for airway hyper responsiveness after the 13th birthday.

f. Chronic obstructive pulmonary disease including but not limited to bullous or generalized pulmonary emphysema or chronic bronchitis.

g. Bronchiectasis (after the 1st birthday).

h. Bronchopleural fistula, unless resolved with no sequelae.

i. Current chest wall malformation, including but not limited to pectus excavatum or pectus carinatum which has been symptomatic, interfered with vigorous physical exertion, has been recommended for surgery, or may interfere with wearing military equipment.

j. History of empyema unless resolved with no sequelae.

k. Interstitial lung disease including pulmonary fibrosis.

l. Current foreign body in lung, trachea, or bronchus.

m. History of thoracic surgery including open and endoscopic procedures.

n. Pleurisy or pleural effusion within the previous 3 months.

o. History of spontaneous pneumothorax occurring within the past 2 years, or pneumothorax due to trauma or surgery occurring within the past year.

p. Recurrent spontaneous pneumothorax.

q. History of chest wall surgery, including breast, during the preceding 6 months, or with persistent functional limitations.

r. Tuberculosis:

(1) History of active pulmonary or extra-pulmonary tuberculosis in the previous 2 years or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment, or

(2) History of latent tuberculosis infection, as defined by current Centers for Disease Control and Prevention guidelines, unless documentation of completion of appropriate treatment.

s. History of pulmonary or systemic embolus.

t. History of other disorders, including but not limited to cystic fibrosis or porphyria, that prevent satisfactorily performing duty, or require frequent or prolonged treatment.

u. History of nocturnal ventilation support, respiratory failure, pulmonary hypertension, or any requirement for chronic supplemental oxygen use.

5.11. HEART.

a. History of valvular repair or replacement.

b. History of the following valvular conditions as listed in the current American College of Cardiology and American Heart Association guidelines and evidenced by echocardiogram within the last 12 months:

(1) Moderate or severe pulmonic regurgitation.

(2) Moderate or severe tricuspid regurgitation.

(3) Moderate or severe mitral regurgitation.

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

(5) Mitral valve prolapse associated with:

(a) Mild or greater mitral regurgitation.

(b) Cardiopulmonary symptoms.

(c) Medical therapy specifically for this condition.

c. Bicuspid aortic valve with any degree of stenosis or regurgitation or aortic dilatation.

d. All valvular stenosis.

e. History of atherosclerotic coronary artery disease.

f. History of pacemaker or defibrillator implantation.

g. History of supraventricular tachycardia if:

(1) History of atrial fibrillation or flutter.

(2) Any atrioventricular nodal reentrant tachycardia or atrioventricular reentrant tachycardia (e.g., Wolff-Parkinson-White syndrome) unless successfully treated with ablative therapy, no recurrence of symptoms after 3 months, and documentation of normal electrocardiograph.

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

i. The following abnormal electrocardiograph patterns:

(1) Long QT.

(2) Brugada pattern.

(3) Pre-excitation pattern, unless it is asymptomatic and associated with low-risk accessory pathway by appropriate diagnostic testing.

j. History of ventricular arrhythmias including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions other than occasional asymptomatic unifocal premature ventricular contractions.

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

l. Any conductive disorder, if symptomatic, including but not limited to:

(1) Sinus arrhythmia.

(2) First degree AV block.

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

(4) Early repolarization.

(5) Incomplete right bundle branch block.

(6) Wandering atrial pacemaker or ectopic atrial rhythm.

(7) Sinus bradycardia.

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

m. History of conduction disturbances, including right bundle branch block, unless it is asymptomatic with a normal echocardiogram.

n. All left bundle branch block, left anterior/posterior hemiblock.

o. History of myocardial infarction, cardiomyopathy, cardiomegaly, hypertrophy (defined as septal wall thickness of 15 mm or greater), or congestive heart failure.

p. History of myocarditis or pericarditis unless the individual is free of all cardiac symptoms, does not require medical therapy, and has normal echocardiography for at least 1 year after the event.

q. History of recurrent myocarditis or pericarditis.

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

s. History of congenital anomalies of the heart and great vessels other than the following conditions. Excepted conditions require an otherwise normal current echocardiogram within the last 12 months.

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

(2) Ligated or occluded patent ductus arteriosus.

(3) Corrected atrial septal defect without residua.

(4) Patent foramen ovale.

(5) Corrected ventricular septal defect without residua.

t. History of recurrent syncope or presyncope, including black out, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture) unless it has not recurred during the preceding 2 years while off all medication for treatment of this condition.

u. Unexplained ongoing or recurring cardiopulmonary symptoms (to include but not limited to syncope, presyncope, chest pain, palpitations, and dyspnea on exertion).

v. History of Postural Orthostatic Tachycardia Syndrome.

w. History of rheumatic fever if associated with rheumatic heart disease or indication for ongoing prophylactic medication.

5.12. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

a. Esophageal Disease.

(1) History of Gastro-Esophageal Reflux Disease, with complications, including, but not limited to:

(a) Stricture.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagus.

(e) Extraesophageal complications such as: reactive airway disease; recurrent sinusitis or dental complications; unresponsive to acid suppression.

(2) History of surgical correction (e.g., fundoplication) for Gastro-Esophageal Reflux Disease within 6 months or with complications.

(3) History of dysmotility disorders to include but not limited to diffuse esophageal spasm, nutcracker esophagus, and achalasia.

(4) History of eosinophilic esophagitis.

(5) History of other esophageal strictures (e.g., from ingesting lye).

(6) History of esophageal disease not specified above; including but not limited to neoplasia, ulceration, varices, or fistula.

b. Stomach and Duodenum.

(1) Current dyspepsia, gastritis, or duodenitis despite medication (over the counter or prescription).

(2) Current gastric or duodenal ulcers, including but not limited to peptic ulcers and gastrojejunal ulcers:

(a) History of a treated ulcer within the last 3 months.

(b) Recurrent or complicated by bleeding, obstruction, or perforation within the previous 5 years.

(3) History of surgery for peptic ulceration or perforated ulcer.

(4) History of gastroparesis of greater than 6 week's duration, confirmed by scintigraphy or equivalent test.

(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) History of inflammatory bowel disease, including but not limited to Crohn's disease, ulcerative colitis, ulcerative proctitis, or indeterminate colitis.

(2) Current infectious colitis.

(3) History of intestinal malabsorption syndromes, including but not limited to celiac sprue, pancreatic insufficiency, post-surgical and idiopathic.

(4) Dietary intolerances that may interfere with military duty or consuming military rations. Lactase deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with military duties.

(5) History of gastrointestinal functional or motility disorders including but not limited to volvulus within the past 24 months, or any history of pseudo-obstruction or megacolon.

(6) Current chronic constipation, requiring prescription medication or medical interventions (e.g., pelvic floor physical therapy, biofeedback therapy).

(7) History of diarrhea of greater than 6 weeks duration, regardless of cause, persisting or symptomatic in the past 2 years.

(8) History of gastrointestinal bleeding, including positive occult blood, if the cause requires treatment and has not been corrected.

(9) History of irritable bowel syndrome of sufficient severity to require frequent intervention or prescription medication or that may reasonably be expected to interfere with military duty.

(10) History of symptomatic diverticular disease of the intestine.

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

d. Hepatic-Biliary Tract.

(1) History of chronic Hepatitis B unless successfully treated and the cure is documented. A documented cure for Hepatitis B is viral clearance manifested by Hepatitis B surface antigen negative/Hepatitis B surface antibody positive/Hepatitis B core antibody positive.

(2) History of chronic Hepatitis C, unless successfully treated and with documentation of a cure 12 weeks after completion of a full course of therapy.

(3) Other acute hepatitis in the preceding 6 months, or persistence of symptoms or abnormal serum aminotransferases after 6 months, or objective evidence of impairment of liver function.

(4) History of cirrhosis, hepatic abscess, or complications of chronic liver disease.

(5) History of symptomatic gallstones or gallbladder disease unless successfully treated.

(6) History of sphincter of Oddi dysfunction.

(7) History of choledochal cyst.

(8) History of primary biliary cirrhosis or primary sclerosing cholangitis.

(9) History of metabolic liver disease, excluding Gilbert's syndrome. This includes but is not limited to hemochromatosis, Wilson's disease, or alpha-1 anti-trypsin deficiency.

(10) History of alcoholic or non-alcoholic fatty liver disease if there is evidence of chronic liver disease, manifested as impairment of liver function or hepatic fibrosis.

(11) History of traumatic injury to the liver within the preceding 6 months.

e. Pancreas. History of:

(1) Pancreatic insufficiency.

(2) Acute pancreatitis, unless due to cholelithiasis successfully treated by cholecystectomy.

(3) Chronic pancreatitis.

(4) Pancreatic cyst or pseudocyst.

(5) Pancreatic surgery.

f. Anorectal.

(1) Current anal fissure or anal fistula.

(2) History of rectal prolapse or stricture within the last 2 years.

(3) History of fecal incontinence after the 13th birthday.

(4) Current hemorrhoid (internal or external), if symptomatic or requiring medical intervention within the last 60 days.

g. Abdominal Wall.

(1) Current abdominal wall hernia other than small (less than 2 centimeters (cm) in size), asymptomatic inguinal or umbilical hernias.

(2) History of open or laparoscopic abdominal surgery during the preceding 3 months.

(3) The presence of any ostomy (gastrointestinal or urinary).

5.13. FEMALE GENITAL SYSTEM.

a. Abnormal uterine bleeding (period greater than 7 days, or more frequent than 21 days or greater than 35 days, or soaking more than one pad per hour for several hours) within the last 12 months.

b. Primary amenorrhea.

c. Current unexplained secondary amenorrhea.

d. Dysmenorrhea resulting in recurrent absences or activity modification within the last 6 months.

e. History of symptomatic endometriosis.

f. History of major abnormalities or defects of the genitalia, such as hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.

g. Current ovarian cyst(s) greater than 5 cm.

h. Polycystic ovarian syndrome unless no evidence of metabolic complications as specified by National Heart, Lung, and Blood Institute and American Heart Association Guidelines.

i. Pelvic inflammatory disease within the preceding 6 months.

j. History of chronic pelvic pain (6 months or longer) within the last 24 months.

k. Pregnancy through 6 months after the completion of the pregnancy.

l. Uterine enlargement due to any cause.

m. History of genital infection or ulceration, including but not limited to herpes genitalis or condyloma acuminatum, if any of the following apply:

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

(3) There have been three or more outbreaks per year.

(4) Any outbreak in the past 12 months that interfered with normal life activities.

(5) After the initial outbreak, treatment that included hospitalization or intravenous therapy.

n. Abnormal gynecologic cytology within the preceding 3 years, including but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix, excluding atypical squamous cells of undetermined significance without human papillomavirus and confirmed low-grade squamous intraepithelial lesion. For the purposes of this issuance, confirmation is by colposcopy or repeat cytology.

o. History of abnormal cervical, vaginal, or vulvar cytology or pathology to include atypical squamous cells that cannot exclude high grade squamous intraepithelial lesions, low-grade squamous intraepithelial lesions, high-grade squamous intraepithelial lesions, cervical intraepithelial neoplasia grades 2 or 3, vaginal intraepithelial neoplasia grades 2 or 3, vulvar intraepithelial neoplasia grades 2 or 3 without demonstrated resolution in accordance with American Society for Colposcopy and Cervical Pathology guidelines.

p. History of abnormal endometrial pathology within the last 3 years (e.g., simple or complex hyperplasia with or without atypia) without demonstrated resolution in accordance with American Society for Colposcopy and Cervical Pathology guidelines.

5.14. MALE GENITAL SYSTEM.

a. Absence of both testicles, current undescended testicle, or congenital absence of one testicle not verified by surgical exploration.

b. History of epispadias or hypospadias when accompanied by history of urinary tract infection, urethral stricture, urinary incontinence, symptomatic chordee, or voiding dysfunction or surgical intervention for these issues within the past 24 months.

c. Current enlargement or mass of testicle, epididymis, or spermatic cord, in addition to those described elsewhere in Paragraph 5.14.

d. Current hydrocele or spermatocele associated with pain or which precludes a complete exam of the scrotal contents.

e. Current varicocele, unless it is:

(1) On the left side only.

(2) Asymptomatic and smaller than the testes.

(3) Reducible.

(4) Without associated testicular atrophy.

f. Current or history of recurrent orchitis or epididymitis.

g. History of penis amputation.

h. Current penile curvature if associated with pain.

i. History of genital infection or ulceration, including but not limited to herpes genitalis or condyloma acuminatum, 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 activities; or

(5) After the initial outbreak, treatment included hospitalization or intravenous therapy.

j. History of urethral condyloma acuminatum.

k. History of acute prostatitis within the last 24 months, history of chronic prostatitis, or history of chronic pelvic pain syndrome.

l. History of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs.

m. History of major abnormalities or defects of the genitalia such as hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.

5.15. URINARY SYSTEM.

a. History of interstitial cystitis or painful bladder syndrome.

b. Lower urinary tract infection (cystitis):

(1) For males, any cystitis not related to an indwelling catheter during a hospitalization.

(2) For females, current cystitis or recurrent cystitis of greater than two episodes per year, or requiring daily suppressive antibiotics, or non-responsive to antibiotics for 10 days.

c. Current urethritis.

d. History or treatment of the following voiding symptoms within the previous 12 months in the absence of a urinary tract infection:

(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.

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

(5) Urinary retention.

(6) Dysuria.

e. History of neurogenic bladder or other functional disorder of the bladder that requires urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

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

g. History of abnormal urinary findings in the absence of urinary tract infection:

(1) Gross hematuria.

(2) Persistent microscopic hematuria (3 or more red blood cells per high-powered field on properly collected urinalyses, unless urology evaluation determines benign essential hematuria).

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

h. Current or recurrent urethral or ureteral stricture or fistula involving the urinary tract.

i. Absence of one kidney, congenital or acquired.

j. Asymmetry in size or function of kidneys.

k. History of renal transplant.

l. Chronic or recurrent pyelonephritis or any other unspecified infections of the kidney.

m. History of polycystic kidney.

n. History of horseshoe kidney.

o. Hydronephrosis on most recent imaging not related to pregnancy.

p. History of acute nephritis or chronic kidney disease of any type as evidenced by 3 months or longer of:

(1) Estimated glomerular filtration rate of less than 60cc per minute per 1.73 square meter of body surface area or abnormal renal imaging;

(2) Casturia; or

(3) Abnormal renal biopsy.

q. History of acute kidney injury requiring dialysis.

r. History of proteinuria with a protein-to-creatinine ratio greater than 0.2 in a random urine sample, more than 48 hours after strenuous activity, excluding benign orthostatic proteinuria.

s. Urolithiasis if any of the following apply:

(1) Current stone of 3 mm or greater.

(2) Current multiple stones of any size.

(3) History of symptomatic urolithiasis within the preceding 12 months.

(4) History of nephrocalcinosis, bilateral renal calculi, or recurrent urolithiasis at any time.

(5) History of urolithiasis requiring a procedure.

5.16. SPINE AND SACROILIAC JOINT CONDITIONS.

a. Ankylosing spondylitis or other inflammatory spondylopathies.

b. History of any condition, in the last 2 years, or any recurrence, 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 avocation in civilian life, or is associated with local or radicular pain, muscular spasms, postural deformities, or limitation in motion;

(2) It requires external support;

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

(4) It requires the applicant to use medication for more than 6 weeks.

(5) It causes one or more episodes of back pain lasting greater than 6 weeks requiring treatment other than self-care.

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

(1) It prevents the individual from following a physically active avocation in civilian life;

(2) It can reasonably be expected to interfere with the proper wearing of military uniform or equipment;

(3) It is symptomatic; or

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

d. History of congenital fusion involving more than 2 vertebral bodies or any surgical fusion of spinal vertebrae.

e. Current dislocation of the vertebra.

f. Vertebral fractures including but not limited to:

(1) Any cervical spine fracture.

(2) History of fracture of lumbar or thoracic vertebral body that exceeds 25 percent of the height of a single vertebra or that has occurred within the last 12 months or is symptomatic.

(3) A history of fractures of the transverse or spinous process if currently symptomatic.

g. History of juvenile epiphysitis with any degree of residual change indicated by X-ray or Scheuermann’s kyphosis.

h. History of uncorrected herniated nucleus pulposus associated with any treatment, symptoms, or activity limitations.

i. History of surgery to correct herniated nucleus pulposus other than a single-level lumbar or thoracic diskectomy that is currently asymptomatic with full resumption of unrestricted activity for at least 12 months.

j. Spinal dysraphisms other than spina bifida occulta.

k. History of spondylolysis or spondylolisthesis, congenital or acquired.

5.17. UPPER EXTREMITY CONDITIONS.

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

(1) Shoulder.

(a) Forward elevation to 130 degrees.

(b) 130 degrees abduction.

(c) 60 degrees external and internal rotation at 90 degrees abduction.

(d) Cross body reaching 115 degrees adduction.

(2) Elbow.

(a) Flexion to 130 degrees.

(b) Extension to 30 degrees.

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

(4) Hand.

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and Thumb. 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.

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

(3) Absence of 2 or more distal and middle phalanges of the middle, ring, or small finger of either hand.

(4) Absence of 2 or more distal phalanges of any finger on either hand.

(5) Absence of hand or any portion thereof, except for specific absence of fingers as noted in Paragraphs 5.17.b.(1)-(4).

(6) Current polydactyly or syndactyly.

(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, 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, pain, sensory disturbance, or other symptoms that may reasonably be expected to prevent satisfactory performance of duty, including but not limited to chronic joint pain associated with the shoulder, the upper arm, the forearm, and the hand; or chronic joint pain as a late effect of fracture of the upper extremities, as a late effect of sprains without mention of injury, and as late effects of tendon injury.

5.18. LOWER EXTREMITY CONDITIONS.

a. General.

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh, lower leg, knee, ankle or foot that prevent the individual from following a physically active avocation in civilian life, or that may reasonably be expected to interfere with walking, running, weight bearing, or with satisfactorily completing training or military duty.

(2) Current discrepancy in leg-length that causes a limp.

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

(1) Hip.

(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.

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle.

(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, other than absence of a single lesser toe that is asymptomatic and does not impair function of the foot.

(2) Deformity of the toes that may reasonably be expected to prevent properly wearing military footwear or impair walking, marching, running, maintaining balance, or jumping.

(3) Symptomatic deformity of the toes (acquired or congenital), including but not limited to conditions such as hallux valgus, hallux varus, hallux rigidus, hammer toe(s), claw toe(s), or overriding toe(s).

(4) Clubfoot or pes cavus that may reasonably be expected to properly wearing military footwear or causes symptoms when walking, marching, running, or jumping.

(5) Rigid or symptomatic pes planus (acquired or congenital).

(6) Current ingrown toenails, if infected or symptomatic.

(7) Current or recurrent plantar fasciitis.

(8) Symptomatic neuroma.

d. Leg, Knee, Thigh, and Hip.

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

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

(3) History of surgical reconstruction of knee ligaments within the last 12 months, or which is symptomatic or unstable or shows signs of thigh or calf atrophy.

(4) Recurrent anterior cruciate ligament reconstruction.

(5) Current medial or lateral meniscal injury with symptoms or limitation of activity.

(6) Surgical meniscal repair, within the last 6 months or with residual symptoms or limitation of activity.

(7) Surgical partial meniscectomy within the last 3 months or with residual symptoms or limitation of activity.

(8) Meniscal transplant.

(9) Symptomatic medial and lateral collateral ligament instability.

(10) History of developmental dysplasia (congenital dislocation) of the hip, osteochondritis of the hip (Legg-Calve-Perthes Disease), or slipped capital femoral epiphysis of the hip.

(11) History of hip dislocation.

(12) Symptomatic osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) within the past 12 months.

(13) Stress fractures, either recurrent or a single episode occurring during the past 12 months.

5.19. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES.

a. History of chondromalacia, including but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome, osteoarthritis, or traumatic arthritis.

b. Dislocation of patella if two or more episodes, or any occurring within the last 12 months.

c. History of any dislocation, subluxation, or instability of the hip, knee, ankle, subtalar joint, foot, shoulder, wrist, elbow except for “nursemaid’s elbow” or dislocated finger.

d Acromioclavicular separation within the last 12 months or if symptomatic.

e. History of osteoarthritis or traumatic arthritis of isolated joints that has interfered with a physically active lifestyle, or that may reasonably be expected to prevent satisfactorily performing military duty.

f. Fractures, if:

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

(2) Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or may reasonably be expected to interfere with properly wearing military equipment or uniforms. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.

g. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities except for bone anchor and hardware as allowed in accordance with Paragraph 5.19.f.(2).

h. History of contusion of bone or joint if:

(1) The injury is of more than a minor nature with or without fracture, nerve injury, open wound, crush, or dislocation which occurred within the last 6 months;

(2) Recovery has not been sufficiently completed or rehabilitation has not been sufficiently resolved;

(3) The injury may reasonably be expected to interfere with or prevent performance of military duty; or

(4) The contusion requires frequent or prolonged treatment.

i. History of joint replacement or resurfacing of any site.

j. History of hip arthroscopy or femoral acetabular impingement.

k. History of neuromuscular paralysis, weakness, contracture, or atrophy not completely resolved and of sufficient degree to reasonably be expected to interfere with or prevent satisfactory performing military duty.

l. Current symptomatic osteochondroma or history of two or more osteocartilaginous exostoses.

m. History of atraumatic fractures or bone mineral density below the expected range for age with risk factors for low bone density.

n. Osteopenia, osteoporosis, or history of fragility fracture.

o. History of osteomyelitis within the past 12 months, or history of recurrent osteomyelitis.

p. History of osteochondral defect, formerly known as osteochondritis dissecans.

q. History of cartilage surgery, including but not limited to cartilage debridement or chondroplasty for Grade III or greater chondromalacia, microfracture, or cartilage transplant procedure.

r. History of any post-traumatic or exercise-induced compartment syndrome.

s. History of osteonecrosis of any bone.

t. History of recurrent tendon disorder, including but not limited to tendonitis, tendonopathy, tenosynovitis.

5.20. VASCULAR SYSTEM.

a. History of abnormalities of the arteries, including but not limited to aneurysms, arteriovenous malformations, atherosclerosis, or arteritis (e.g., Kawasaki's disease).

b. Current or medically-managed hypertension. Hypertension is defined as systolic pressure greater than 140 millimeters of mercury (mmHg) 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 separate days within a 5-day period (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 separate days within a 5-day period).

c. History of peripheral vascular disease, including but not limited to diseases such as Raynaud's Disease and vasculitides.

d. History of venous diseases, including but not limited to recurrent thrombophlebitis, thrombophlebitis during the preceding year, or evidence of venous incompetence, such as edema, skin ulceration, or symptomatic varicose veins that would reasonably be expected to limit duty or properly wearing military uniform or equipment.

e. History of deep venous thrombosis.

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.

g. History of Marfan's Syndrome, Loey-Dietz, or Ehlers Danlos IV.

5.21. SKIN AND SOFT TISSUE CONDITIONS.

a. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (e.g. Accutane®), do not meet the standard until 4 weeks after completing therapy.

b. Severe nodulocystic acne, on or off antibiotics.

c. History of dissecting scalp cellulitis, acne inversa, or hidradenitis suppurativa.

d. History of atopic dermatitis or eczema after the 12th birthday. History of residual or recurrent lesions in characteristic areas (face, neck, antecubital or popliteal fossae, occasionally wrists and hands).

e. History of recurrent or chronic non-specific dermatitis within the past 2 years to include contact (irritant or allergic) or dyshidrotic dermatitis requiring more than treatment with topical corticosteroid.

f. Cysts, if:

(1) The current cyst (other than pilonidal cyst) is of such a size or location as to reasonably be expected to interfere with properly wearing military equipment.

(2) The current pilonidal cyst is associated with a tumor mass or discharging sinus, or is a surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-operative. A pilonidal cyst that has been simply incised and drained does not meet the military accession medical entrance standard.

g. History of bullous dermatoses, including but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa.

h. Current or chronic lymphedema.

i. History of furunculosis or carbuncle if extensive, recurrent, or chronic.

j. History of severe hyperhidrosis of hands or feet unless controlled by topical medications.

k. History of congenital or acquired anomalies of the skin, such as nevi or vascular tumors that may interfere with military duties or cause constant irritation.

l. History of severe keloid formation.

m. History of pseudofolliculitis barbae or keloidalis nuchae, severe enough to prevent daily shaving or would reasonably be expected to interfere with wearing military equipment.

n. Current lichen planus (either cutaneous or oral).

o. History of oculocutaneous albinism, Neurofibromatosis I (Von Recklinghausen's Disease), Neurofibromatosis II, and tuberous sclerosis.

p. History of photosensitivity, 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, porphyria, and xeroderma pigmentosa.

q. History of psoriasis excluding non-recurrent childhood guttate psoriasis.

r. History of chronic radiation dermatitis (radiodermatitis).

s. History of scleroderma.

t. History of chronic urticaria lasting longer than 6 weeks even, if it is asymptomatic when controlled by daily maintenance therapy.

u. Current symptomatic plantar wart(s).

v. Current scars that can reasonably be expected to interfere with properly wearing military clothing or equipment, or to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, or agility.

w. Prior burn 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 satisfactorily performing military duty due to pain or decreased range of motion, strength, temperature regulation, or agility.

x. Current localized fungal infections, if they can be reasonably expected to interfere with properly wearing military equipment or performing military duties. For systemic fungal infections, refer to Paragraph 5.23.s.

y. History of any medical condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

z. Conditions with malignant potential in the skin including but not limited to basal cell nevus syndrome, oculocutaneous albinism, xeroderma pigmentosum, Muir-Torre Syndrome, Dyskeratosis Congenita, Gardner Syndrome, Peutz-Jeghers Syndrome, Cowden Syndrome, Multiple Endocrine Neoplasia, Familial Atypical Multiple Mole Melanoma Syndrome, and Birt-Hogg-Dube Syndrome.

aa. History of cutaneous malignancy before the 25th birthday including but not limited to basal cell carcinoma and squamous cell carcinoma. History of the following skin cancers at any age: malignant melanoma, Merkel cell carcinoma, sebaceous carcinoma, Paget's disease, extramammary Paget's disease, microcystic adnexal carcinoma, other adnexal neoplasms, and cutaneous lymphoma including mycosis fungoides.

ab. History of lupus erythematosus.

ac. History of congential disorders of cornification including but not limited to ichthyosis vulgaris, x-linked ichthyosis, lamellar ichthyosis, Darier's Disease, Epidermal Nevus Syndrome, and any palmo-plantar keratoderma.

ad. History of congenitalal disorder of the hair and nails including but not limited to pachyonychia congenita or ectodermal dysplasia.

ae. History of dermatomyositis.

5.22. BLOOD AND BLOOD FORMING SYSTEM.

a. Current hereditary or acquired anemia.

b. History of coagulation defects.

c. Any history of chronic, or recurrent thrombocytopenia.

d. History of deep venous thrombosis or pulmonary embolism.

e. History of chronic or recurrent agranulocytosis or leukopenia.

f. History of chronic polycythemia, chronic leukocytosis or chronic thrombocytosis.

g. Disorders of the spleen including:

(1) Current splenomegaly.

(2) History of splenectomy.

5.23. SYSTEMIC CONDITIONS.

a. History of disorders involving the immune mechanism, including immunodeficiencies.

b. Presence of human immunodeficiency virus or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s).

c. Tuberculosis.

(1) History of active pulmonary or extra pulmonary tuberculosis in the previous 2 years or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment.

(2) History of latent tuberculosis infection, as defined by current Centers for Disease Control guidelines, unless documentation of completion of appropriate treatment.

d. History of syphilis without appropriate documentation of treatment and cure.

e. History of anaphylaxis. Anaphylaxis is highly likely when any one of the following three criteria are fulfilled:

(1) Acute onset of an illness (minutes to several hours) with involvement of the skin, mucosal tissue, or both (e.g., generalized hives, pruritus or flushing, swollen lips-tongue-uvula) and at least one of the following:

(a) Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia); or

(b) Reduced blood pressure (BP) or associated symptoms of end-organ dysfunction (e.g., hypotonia [collapse], syncope, incontinence).

(2) Two or more of the following that occur rapidly after exposure to a likely allergen for that patient (minutes to several hours):

(a) Involvement of the skin-mucosal tissue (e.g., generalized hives, itch-flush, swollen lips-tongue-uvula).

(b) Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia).

(c) Reduced BP or associated symptoms (e.g., hypotonia [collapse], syncope, incontinence).

(d) Persistent gastrointestinal symptoms (e.g., crampy, abdominal pain, vomiting).

(3) Reduced blood pressure after exposure to known allergen for that patient (minutes to several hours):

(a) Infants and Children: Low systolic BP (less than 70 mmHg from 1 month to 1 year, less than (70 mmHg + [2×age]) from 1 to 10 years, and less than 90 mm Hg from 11 to 17 years) or greater than 30 percent decrease in systolic blood pressure.

(b) Adults: Systolic BP of less than 90 mmHg or greater than 30 percent decrease from that person's baseline.

f. History of systemic allergic reaction to biting or stinging insects, unless it was limited to a large local reaction, a cutaneous only reaction (including hives) occurring under the age of 16, or unless there is documentation of 3-5 years of maintenance venom immunotherapy.

g. History of acute allergic reaction to fish, shellfish, peanuts, or tree nuts including the presence of a food-specific immunoglobulin E antibody if accompanied by a correlating clinical history.

h. History of cold urticaria.

i. History of malignant hyperthermia.

j. History of industrial solvent or other chemical intoxication with sequelae.

k. History of motion sickness resulting in recurrent incapacitating symptoms.

l. History of rheumatic fever if associated with rheumatic heart disease or indication for ongoing prophylactic medication.

m. History of muscular dystrophies or myopathies.

n. History of amyloidosis.

o. History of eosinophilic granuloma and all other forms of histiocytosis except for healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement.

p. History of polymyositis or dermatomyositis complex with or without skin involvement.

q. History of rhabdomyolysis.

r. History of sarcoidosis.

s. Current active systemic fungus infections or ongoing treatment for systemic fungal infection. History of systemic fungal infection unless resolved or treated without sequelae.

5.24. ENDOCRINE AND METABOLIC CONDITIONS.

a. Current adrenal dysfunction or any history of adrenal dysfunction requiring treatment or hormone replacement.

b. Diabetic disorders, including:

(1) History of diabetes mellitus.

(2) History of unresolved pre-diabetes mellitus (as defined by the American Diabetes Association) within the last 2 years.

(3) History of gestational diabetes mellitus.

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

c. History of pituitary dysfunction except for resolved growth hormone deficiency.

d. History of pituitary tumor unless proven non-functional, less than 1 cm and stable in size for the last 12 months.

e. History of diabetes insipidus.

f. History of primary hyperparathyroidism unless surgically corrected.

g. History of hypoparathyroidism.

h. Current goiter.

i. Thyroid nodule unless a solitary thyroid nodule less than 5 mm or less than 3 cm with benign histology or cytology, and that does not require ongoing surveillance.

j. History of complex thyroid cyst or simple thyroid cyst greater than 2 cm.

k. Current hypothyroidism unless asymptomatic and demonstrated euthyroid by normal thyroid stimulating hormone testing within the preceding 12 months.

l. History of hyperthyroidism unless treated successfully with surgery or radioactive iodine.

m. Current nutritional deficiency diseases, including but not limited to beriberi, pellagra, and scurvy.

n. Dyslipidemia with low-density lipoprotein greater than 200 milligrams per deciliter (mg/dL) or triglycerides greater than 400 mg/dL. Dyslipidemia requiring more than one medication or low-density lipoprotein greater than 190 mg/dL on therapy. All those on medical management must have demonstrated no medication side effects (e.g., myositis, myalgias, or transaminitis) for a period of 6 months.

o. Metabolic syndrome, as defined in accordance with the 2005 National Heart, Lung, and Blood Institute and American Heart Association Scientific Statement 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.

p. Metabolic bone disease including but not limited to:

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

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

q. History of hypogonadism that is congenital, treated with hormonal supplementation, or of unexplained etiology.

r. History of islet-cell tumors, nesideoblastosis, or hypoglycemia.

s. History of gout.

5.25. RHEUMATOLOGIC CONDITIONS.

a. History of mixed connective tissue disease variant or systemic lupus erythematosus.

b. History of progressive systemic sclerosis, including calcinosis, Raynaud's phenomenon, esophageal dysmotility, scleroderma, or telangiectasia syndrome.

c. History of reactive arthritis (formerly known as Reiter's disease).

d. History of rheumatoid arthritis.

e. History of Sjögren's syndrome.

f. History of vasculitis, including but not limited to polyarteritis nodosa, arteritis, Behçet's, Takayasu's arteritis, and Anti Neutrophil Cytoplasmic Antibody associated vasculitis.

g. History of Henoch-Schonlein Purpura occurring after the 19th birthday or within the last 2 years.

h. History of non-inflammatory myopathy including but not limited to metabolic myopathy such as glycogen storage disease, lipid storage disease, and mitochondrial myopathy.

i. History of fibromyalgia or myofascial pain syndrome.

j. History of chronic wide-spread pain requiring prescription medication for greater than 6 weeks within the last 2 years.

k. History of chronic fatigue syndrome, systemic exertion intolerance disease, or chronic multisystem illness.

l. History of spondyloarthritis including but not limited to ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis, or spondyloarthritis associated with inflammatory bowel disease.

m. History of joint hypermobility syndrome (formerly Ehler's Danlos syndrome, Type III).

n. Any history of connective tissue disease including but not limited to Ehlers-Danlos syndrome, Marfan syndrome, Pseudoxanthoma Elasticum, and osteogenesis imperfecta.

o. History of scleroderma.

p. History of IgG-4 related disease.

q. History of polymyositis or dermatomyositis complex, with or without skin involvement.

5.26. NEUROLOGIC CONDITIONS.

a. History of cerebrovascular conditions, including but not limited to subarachnoid or intracerebral hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation.

b. History of congenital or acquired anomalies of the central nervous system or meningocele.

c. History of disorders of meninges, including but not limited to cysts except for asymptomatic incidental arachnoid cysts demonstrated to be stable by neurological imaging over a 6-month or longer time period.

d. History of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum, basal ganglia, cerebellum, spinal cord, peripheral nerves, or muscles.

e. History of headaches, including but not limited to, migraines and tension headaches that:

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

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

(3) Are associated with neurological deficit other than scotoma.

f. Cluster headaches.

g. History of moderate or severe brain injury 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) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging;

(6) Associated abscess or meningitis;

(7) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days;

(8) Penetrating head trauma to include radiographic evidence of retained foreign body or bony fragments secondary to the trauma, or operative procedure in the brain; or

(9) Any skull fracture.

h. History of mild brain injury if:

(1) The injury occurred within the past month;

(2) Neurological evaluation shows residual symptoms, dysfunction or activity limitations, or complications;

(3) Two episodes of mild brain injury occurred with or without loss of consciousness within the last 12 months; or

(4) Three or more episodes of mild brain injury.

i. History of persistent post-concussive symptoms that interfere with normal activities or have duration of more than 1 month. 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.

j. History of infectious processes of the central nervous system, including but not limited to encephalitis, neurosyphilis, or brain abscess.

k. History of meningitis within the last 12 months or with persistent neurologic defects.

l. History of paralysis, weakness, lack of coordination, chronic pain syndrome (including but not limited to complex regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes, including but not limited to Guillain-Barre Syndrome.

m. Any atraumatic seizure occurring after 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.

n. Chronic nervous system disorders, including but not limited to myasthenia gravis, multiple sclerosis, tremor, and tic disorders (e.g., Tourette's Syndrome).

o. History of central nervous system shunts of all kinds including endoscopic third ventriculocisternostomy.

p. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope, 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.

q. History of muscular dystrophies or myopathies.

5.27. SLEEP DISORDERS.

a. Chronic insomnia as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or the use of medications or other substances to promote sleep 15 or more times over the past year.

b. Current diagnosis or treatment of sleep-related breathing disorders, including but not limited to sleep apnea.

c. History of narcolepsy, cataplexy, or other hypersomnia disorders.

d. Circadian rhythm disorders requiring treatment or special accommodation.

e. History of parasomnia, including but not limited to sleepwalking, or night terrors, after the 13th birthday.

f. Current diagnosis or treatment of sleep-related movement disorders to include but not limited to restless leg syndrome (i.e., Willis-Ekbom Disease) for which prescription medication is recommended.

5.28. LEARNING, PSYCHIATRIC, AND BEHAVIORAL DISORDERS.

a. Attention Deficit Hyperactivity Disorder, if with:

(1) A recommended or prescribed Individualized Education Program, 504 Plan, or work accommodations after the 14th birthday;

(2) A history of comorbid mental disorders;

(3) Prescribed medication in the previous 24 months; or

(4) Documentation of adverse academic, occupational, or work performance.

b. History of learning disorders after the 14th birthday, including but not limited to dyslexia, if any of the following apply:

(1) With a recommended or prescribed Individualized Education Program, 504 Plan, or work accommodations after the 14th birthday;

(2) With a history of comorbid mental disorders; or

(3) With documentation of adverse academic, occupational, or work performance.

c. Autism spectrum disorders.

d. History of disorders with psychotic features such as schizophrenic disorders, delusional disorders, or other unspecified psychoses or mood disorders with psychotic features.

e. History of bipolar and related disorders (formerly identified as mood disorders not otherwise specified) including but not limited to cyclothymic disorders and affective psychoses.

f. Depressive disorder if:

(1) Outpatient care including counseling required for longer than 12 cumulative months;

(2) Symptoms or treatment within the last 36 months;

(3) The applicant required any inpatient treatment in a hospital or residential facility;

(4) Any recurrence; or

(5) Any suicidality (in accordance with Paragraph 5.28.m.).

g. History of a single adjustment disorder if treated or symptomatic within the previous 6 months, or any history of chronic (lasting longer than 6 months) or recurrent episodes of adjustment disorders.

h. History of disruptive, impulse control and conduct disorder to include but not limited to oppositional defiant and other behavior disorders.

i. Any personality disorder including unspecified personality disorder or maladaptive personality traits demonstrated by:

(1) Repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, other social groups, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency may reasonably be expected to interfere with their adjustment to 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; or

(3) Any behavioral health issues that have led to incarceration for any period.

j. Encopresis after 13th birthday.

k. History of any feeding or eating disorder.

l. Any current communication disorder that significantly interferes with producing speech or repeating commands.

m. Suicidality, including suicidal ideation with a plan, suicidal gesture(s), or attempt(s).

n. History of self-mutilation.

o. History of obsessive-compulsive disorder.

p. History of post-traumatic stress disorder.

q. History of anxiety disorders if:

(1) Outpatient care including counseling was required for longer than 12 cumulative months.

(2) Symptomatic or treatment within the last 36 months.

(3) The applicant required any inpatient treatment in a hospital or residential facility.

(4) Any recurrence.

(5) Any suicidality (in accordance with Paragraph 5.28.m.).

r. History of dissociative disorders.

s. History of somatic symptoms and related disorders.

t. History of paraphilic disorders.

u. Any history of substance-related and addictive disorders (except using caffeine or tobacco).

v. History of other mental disorders that may reasonably be expected to interfere with or prevent satisfactory performance of military duty.

w. Prior psychiatric hospitalization for any cause.

5.29. TUMORS AND MALIGNANCIES.

a. Current benign tumors or conditions that would reasonably be expected to interfere with function, to prevent properly wearing the uniform or protective equipment, or would require frequent specialized attention.

b. History of malignancy.

c. History of cutaneous malignancy, meeting criteria in Paragraph 5.21.aa.

5.30. MISCELLANEOUS CONDITIONS.

a. Any current acute pathological condition, including but not limited to communicable, infectious, parasitic, or tropical diseases, until recovery has occurred without relapse or sequelae.

b. History of porphyria.

c. History of cold-related disorders, including but not limited to frostbite, chilblain, and immersion foot.

d. History of angioedema, including hereditary angioedema.

e. History of receiving organ or tissue transplantation other than dental.

f. History of pulmonary or systemic embolism.

g. History of untreated acute or chronic metallic poisoning (including but not limited to lead, arsenic, silver, beryllium, or manganese), or current complications or residual symptoms of such poisoning.

h. History of heatstroke, or heat injury with evidence of organ or muscle damage, or recurrent heat exhaustion.

i. History of any condition that may reasonably be expected to interfere with the successful performance of military duty or training or limit geographical assignment.

j. History of any medical condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

GLOSSARY

G.1. ACRONYMS.

ASD(HA)	Assistant Secretary of Defense for Health Affairs
AV	atrioventricular
BP	blood pressure
cm	centimeters
dB	decibel
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dL	milligrams per deciliter
mm	millimeters
mmHg	millimeters of mercury
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USMEPCOM	United States Military Entrance Processing Command

G.2. DEFINITIONS. Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

504 Plan. The 504 Plan is a plan developed to ensure that a child who has a disability identified under Section 504 of the Rehabilitation Act of 1973 as amended and codified at Section 701 of Title 29, U.S.C. and is attending an elementary or secondary educational institution, receives accommodations that will ensure their academic success and access to the learning environment.

accession. An enlistment that increases the incremental strength of the Regular or Reserve Components of the Military Services. Personnel enlisted under the Delayed Entry Program are not involved in this category.

existed prior to Service. A term used to signify there is clear and unmistakable evidence that the disease or injury, or the underlying condition producing the disease or injury, existed prior to the individual's entry into military service.

induction. Transition from civilian to military status for a period of definite military obligation under Chapter 49 of Title 50, U.S.C. also known as the "Military Selective Service Act."

medical waiver. A formal request to consider the suitability for service of an applicant who, because of current or past medical conditions, does not meet medical standards. Upon the completion of a thorough review, the applicant may be considered for a waiver. The applicant must have displayed sufficient mitigating circumstances/provided medical documentation that

clearly justify waiver consideration. The Secretaries of the Military Departments may delegate the final approval authority for all waivers.

mild head injury. Unconsciousness of less than 30 minutes post-injury, or amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.

MEDPERS. Includes leaders from the medical and personnel communities to develop, discuss, and make decisions about common medical issues that require resolution. The primary focus is the nexus of medical and personnel systems that impact the total force to include those seeking entry into the armed forces and those who must depart prior to completion of an enlistment or career.

Military Department. Defined in the DoD Dictionary of Military and Associated Terms.

moderate brain injury. Unconsciousness of more than 30 minutes but less than 24 hours, or amnesia, or disorientation of person, place or time, alone or in combination, lasting more than 24 hours but less than 7 days after the injury.

National Heart, Lung, and Blood Institute. An agency within the National Institutes of Health 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.

severe brain injuries. Unconsciousness of 24 hours or more post injury, or amnesia or disorientation of person, place or time longer than 7 days after the-injury.

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United States Code, Title 18, Section 1001

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[1] Available at https://catalog.ama-assn.org/Catalog/cpt/cpt_home.jsp

[2] Available for purchase at http://www.ansi.org/

[3] Available at http://www.cdc.gov/nchs/icd/icd10cm.htm#icd2016.

Exhibit 4

Declaration of Major Sean M. Heenan,

dated June 6, 2018

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE 2, et al.	)	
	)	
Plaintiffs,	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
	)	
DONALD TRUMP, et al.	)	
	)	
Defendants.	)	
	)	

DECLARATION OF MAJ SEAN M. HEENAN
(Pertaining to Plaintiff Dylan Kohere)

I, Sean M. Heenan, hereby declare as follows:

1. I am currently the Acting Professor of Military Science (PMS) and Executive Officer of the U.S. Army Reserve Officer Training Corps (ROTC) detachment at the University of Connecticut in Storrs, Connecticut, which oversees and administers the satellite ROTC program at the University of New Haven in New Haven, Connecticut. I have been in this position since May 22nd 2018. I am responsible for the administration of the ROTC program at the University of New Haven, including all personnel-related activities involving the participation and enrollment of students in ROTC. Due to my official duties related to these responsibilities, I have an understanding of U.S. Army Cadet Command's policy regarding the various levels of students' participation in the ROTC program.

2. I am aware of the allegations made by Dylan Kohere in the filings and his associated declaration in *Jane Doe 2 v. Trump*, No. 17-cv-1597, currently pending in the United States District Court for the District of Columbia. Based upon my knowledge of his allegations, and information that I have learned through my official duties, I offer the following:

a. Dylan Kohere is a self-identified transgender student at the University of New Haven who participated in ROTC as a freshman throughout the fall and spring semesters of the 2017-

2018 academic year. He was registered in the Military Science I (MS-I) classes both semesters and, in accordance with Cadet Command policy, was able to participate in certain labs that did not include physical activity.

b. While Mr. Kohere was only authorized to participate in ROTC his first semester, the Department of Defense updated its medical fitness standards for accession into the military, effective January 1, 2018. Based on this new policy guidance, the cadre at the University of New Haven attempted to contact Mr. Kohere on 7 February 2018 in person, 19 April 2018 via email, and 25 April 2018 in person, in order to discuss his potential eligibility to enroll in ROTC Mr. Kohere, however, never responded to any of the cadre's communications, and has not otherwise attempted to discuss his potential enrollment. He also did not attend his MS-I classes for 2 days during the semester. Since then he has not communicated with my cadre and has not indicated whether he intends to continue participating or will attempt to enroll in ROTC during his sophomore year. Based on the information currently available to me, he has not registered for the MS-II class (or any other class in the ROTC curriculum) for the upcoming Fall semester.

c. I am aware of Dylan Kohere's allegation that he does not have the opportunity to apply for an academic scholarship. Based on the Department's new accessions guidance Mr. Kohere may apply and compete for a three- or two-year scholarship, but he is not eligible until he is enrolled as a cadet in ROTC. He cannot be enrolled, however, due to his non-compliance with my cadre's requests to discuss his enrollment, and therefore he is currently not eligible for a scholarship.

In accordance with 28 U.S.C. §1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 6th day of June 2018.

Sean M. Heenan
Major, U.S. Army
U.S. Army Cadet Command

Exhibit 5

USCENTCOM Minimal Deployment Standards,

dated March 23, 2017

USCENTCOM 231245Z MAR 17 MOD THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL-UNIT DEPLOYMENT POLICY

UNCLASSIFIED//

SUBJ/MOD THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY//

REF/A/MSG/CDRUSCENTCOM/SG/032024ZOCT2001//
AMPN/ORIGINAL USCINCCENT INDIVIDUAL PROTECTION AND INDIVIDUAL UNIT DEPLOYMENT POLICY MESSAGE//

REF/B/MSG/CDRUSCENTCOM/SG/021502ZDEC2013//
AMPN/MOD TWELVE TO USCENTCOM INDIVIDUAL PROTECTION AND UNIT DEPLOYMENT POLICY MESSAGE. MOD TWELVE IS NO LONGER VALID AND IS SUPERSEDED BY MOD THIRTEEN//

REF/C/DOC/USD(P&R)/11AUG2006, CERTIFIED 30SEP2011//
AMPN/DODI 6490.03/DEPLOYMENT HEALTH//

REF/D/DOC/USD(P&R)/09JUN2014//
AMPN/DODI 6025.19/INDIVIDUAL MEDICAL READINESS//

REF/E/DOC/COMDT CG/22AUG2014//
AMPN/COMDTINST M6000.1F/COAST GUARD MEDICAL MANUAL//

REF/F/DOC/SECAF/AS UPDATED 27AUG2015//
AMPN/AFI 48-123/MEDICAL EXAMINATIONS AND STANDARDS //

REF/G/DOC/HQDA/14DEC2007 WITH RAR 04AUG2011//
AMPN/AR 40-501/STANDARDS OF MEDICAL FITNESS//

REF/H/DOC/BUMED/11JUN2015//
AMPN/NAVMED P-117/MANUAL OF THE MEDICAL DEPARTMENT//

REF/I/DOC/USD(P&R)/05FEB2010//
AMPN/DODI 6490.07/DEPLOYMENT-LIMITING MEDICAL CONDITIONS FOR SERVICE MEMBERS AND DOD CIVILIAN EMPLOYEES//

REF/J/DOC/USD(P&R)/20DEC2011//
AMPN/DODI 3020.41/OPERATIONAL CONTRACT SUPPORT//

REF/K/ORD/CFC/010458ZJUL2006//
AMPN/CFC FRAGO 09-1038/CONTRACTOR CARE IN THE USCENTCOM AOR//

REF/L/DOC/USD(P&R)/23JAN2009//
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REF/M/DOC/ASD(FMP)/11MAR2002, AS AMENDED 26DEC2002//
AMPN/DODI 1100.21/VOLUNTARY SERVICES IN THE DEPARTMENT OF DEFENSE//

REF/N/DOC/DEPSECDEF/12OCT2006//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/ANTHRAX VACCINE IMMUNIZATION PROGRAM//

REF/O/DOC/ASD(P&R)/09OCT2004//
AMPN/DODD 6200.04/FORCE HEALTH PROTECTION (FHP)//

REF/P/DOC/USD(P&R)/09FEB2006//
AMPN/UNDER SECRETARY OF DEFENSE MEMO/POLICY GUIDANCE FOR MEDICAL DEFERRAL PENDING DEPLOYMENT TO THEATERS OF OPERATION//

REF/Q/DOC/HQDA/BUMED/SECAF/07OCT2013//
AMPN/AR 40-562, BUMEDINST 6230.15B, AFI 48-110 IP, CG COMDTINST M6230.4G/ IMMUNIZATIONS AND CHEMOPROPHYLAXIS FOR THE PREVENTION OF INFECTIOUS DISEASES//

REF/R/DOC/DEPSECDEF/12NOV2015//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/CLARIFYING GUIDANCE FOR SMALLPOX AND ANTHRAX VACCINE IMMUNIZATION PROGRAMS//

REF/S/DOC/ASD(HA)/31JUL2009//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL POLICY FOR THE ADMINISTRATION OF THE ANTHRAX VACCINE ABSORBED//

REF/T/DOC/USD(P&R)/07JUN2013//
AMPN/DODI 6485.01/HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN MILITARY SERVICE MEMBERS//

REF/U/DOC/ASD(HA)/14MAR2006//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/POLICY FOR PRE AND POST DEPLOYMENT SERUM COLLECTION//

REF/V/DOC/ASD(P&R)/17JUL2015//
AMPN/DODI 6465.1/ERYTHROCYTE GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY (G6PD) AND SICKLE CELL TRAIT SCREENING PROGRAMS//

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AMPN/DODI 5154.30/ARMED FORCES INSTITUTE OF PATHOLOGY OPERATIONS//

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REF/Y/DOC/ASD(HA)/26JUL2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/IMPLEMENTATION OF REVISED DEPARTMENT OF DEFENSE FORMS 2795, 2796 AND 2900//

REF/Z/DOC/USD(P&R)/11SEP2015//

AMPN/DODI 6490.13/COMPREHENSIVE POLICY ON TRAUMATIC BRAIN INJURY-RELATED NEUROCOGNITIVE ASSESSMENTS BY THE MILITARY SERVICES//

REF/AA/USD(P&R)/ 26FEB2013, AS AMENDED 25JAN2017//
AMPN/DODI 6490.12/MENTAL HEALTH ASSESSMENT FOR SERVICE MEMBERS DEPLOYED IN CONNECTION WITH A CONTINGENCY OPERATION//

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AMPN/DODI 6420.01/NATIONAL CENTER MEDICAL INTELLIGENCE (NCMI)//

REF/CC/DOC/ASD(HA)/15APR2013//
AMPN/GUIDANCE ON MEDICATIONS FOR THE PROPHYLAXIS OF MALARIA//

REF/DD/DOC/ASD(HA)/12AUG2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/NOTIFICATION FOR HEALTHCARE PROVIDERS OF MEFLOQUINE BOX WARNING//

REF/EE/DOC/ASD(HA)/18MAY2007//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/UPDATED POLICY FOR PREVENTION OF ARTHROPOD-BORNE DISEASES AMONG DEPARTMENT OF DEFENSE PERSONNEL DEPLOYED TO ENDEMIC AREAS//

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REF/HH/DOC/AFHSC/MAR2012//
AMPN/ARMED FORCES REPORTABLE MEDICAL EVENTS GUIDELINES & CASE DEFINITIONS//

REF/II/ DOC/CENTCOM/OCT2012//
AMPN/UNITED STATES CENTRAL COMMAND HEALTHCARE INFORMATION SYSTEM USE POLICY//

REF/JJ/DOC/USD(P&R)/18SEP2012//
AMPN/DODI 6490.11/DOD POLICY GUIDANCE FOR MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY/ AND CONCUSSION IN THE DEPLOYED SETTING//

REF/KK/DOC/ASD(HA)/07OCT2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL PRACTICE GUIDELINES FOR DEPLOYMENT LIMITING MENTAL DISORDERS AND PSYCHOTROPIC MEDICATIONS//

RMKS/1. (U) THIS IS MODIFICATION THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY. IN SUMMARY, MODIFICATIONS HAVE BEEN MADE TO PARAGRAPH 15 FROM MOD TWELVE, REF B.
1.A. PARAGRAPH 15 REQUIRED NUMEROUS CHANGES; THEREFORE, IT IS BEING REPUBLISHED IN ITS ENTIRETY. MOD 13 SUPERSEDES ALL PREVIOUS VERSIONS.
1.B. PARAGRAPH 15 OF REF A HAS BEEN TOTALLY REWRITTEN AS FOLLOWS:
15.A. DEFINITIONS.

15.A.1. DEPLOYMENT. FOR MEDICAL PURPOSES, THE DEFINITION OF DEPLOYMENT IS TRAVEL TO OR THROUGH THE USCENTCOM AREA OF RESPONSIBILITY (AOR), WITH EXPECTED OR ACTUAL TIME IN COUNTRY (PHYSICALLY PRESENT, EXCLUDING IN-TRANSIT OR TRAVEL TIME) FOR A PERIOD OF GREATER THAN 30 DAYS, EXCLUDING SHIPBOARD OPERATIONS, AS DEFINED IN REF C.

15.A.2. TEMPORARY DUTY (TDY). TDY MISSIONS ARE THOSE MISSIONS WITH TIME IN COUNTRY OF 30 DAYS OR LESS.

15.A.3. PERMANENT CHANGE OF STATION (PCS). PCS PERSONNEL, INCLUDING EMBASSY PERSONNEL, WILL COORDINATE WITH THEIR RESPECTIVE SERVICE COMPONENT MEDICAL PERSONNEL FOR MEDICAL GUIDANCE AND REQUIREMENTS FOR PCS TO SPECIFIC COUNTRIES IN THE USCENTCOM AOR. AUTHORIZED DEPENDENTS MUST PROCESS THROUGH THE OVERSEAS SCREENING PROCESS AND EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP), IF REQUIRED. ALL PERSONNEL MUST BE CURRENT WITH ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) IMMUNIZATION GUIDELINES AND DOD TRAVEL GUIDELINES IAW REF C. HOST NATION IMMUNIZATION AND MEDICAL SCREENING REQUIREMENTS APPLY. PORTIONS OF MOD 13 WILL APPLY AS DELINEATED IN TAB B.

15.A.4. SHIPBOARD PERSONNEL. ALL SHIPBOARD PERSONNEL WHO DEPLOY INTO THE AOR MUST HAVE CURRENT SEA DUTY SCREENING AND REMAIN FULLY MEDICALLY READY FOLLOWING ANNUAL PERIODIC HEALTH ASSESSMENT (PHA). DEPLOYMENT HEALTH ASSESSMENT PER 15.H APPLIES IF DEPLOYED TO OCONUS FOR GREATER THAN 30 DAYS WITH NON-FIXED U.S. MEDICAL TREATMENT FACILITIES (MTFS).

15.B. APPLICABILITY. THIS MOD APPLIES TO U. S. MILITARY PERSONNEL, TO INCLUDE ACTIVATED RESERVE AND NATIONAL GUARD PERSONNEL, DOD CIVILIANS, DOD CONTRACTORS, DOD SUB-CONTRACTORS, VOLUNTEERS, AND THIRD COUNTRY NATIONALS (TCN) TRAVELING OR DEPLOYING TO THE CENTCOM AOR AND WORKING UNDER THE AUSPICES OF THE DOD. LOCAL NATIONALS (LN) SHOULD MEET THE MINIMAL MEDICAL STANDARDS ADDRESSED IN SECTION 15.C.1.F.

15.C. MEDICAL DEPLOYABILITY. DEPLOYED HEALTH SERVICE SUPPORT INFRASTRUCTURE IS DESIGNED AND PRIORITIZED TO PROVIDE ACUTE AND EMERGENCY SUPPORT TO THE EXPEDITIONARY MISSION. ALL PERSONNEL (UNIFORMED SERVICE MEMBERS, GOVERNMENT CIVILIAN EMPLOYEES, VOLUNTEERS, DOD CONTRACTOR EMPLOYEES) TRAVELING TO THE CENTCOM AOR MUST BE MEDICALLY, DENTALLY AND PSYCHOLOGICALLY FIT. INDIVIDUALS DEEMED UNABLE TO COMPLY WITH CENTCOM DEPLOYMENT REQUIREMENTS ARE DISQUALIFIED FOR DEPLOYMENT IAW SERVICE POLICY AND MOD 13. PERSONNEL FOUND TO BE MEDICALLY NON-DEPLOYABLE WHILE OUTSIDE OF THE CENTCOM AOR FOR ANY LENGTH OF TIME WILL NOT ENTER OR RE-ENTER THE THEATER UNTIL THE NON-DEPLOYABLE CONDITION IS COMPLETELY RESOLVED OR AN APPROVED WAIVER FROM A CENTCOM WAIVER AUTHORITY IS OBTAINED. SEE REF D, E, F, G AND H. DOD CIVILIAN EMPLOYEES ARE COVERED BY THE REHABILITATION ACT OF 1973. AS SUCH, AN APPARENTLY DISQUALIFYING MEDICAL CONDITION NEVERTHELESS REQUIRES THAT AN INDIVIDUALIZED ASSESSMENT BE MADE TO DETERMINE WHETHER THE EMPLOYEE CAN PERFORM THE ESSENTIAL FUNCTIONS OF THEIR POSITION IN THE DEPLOYED ENVIRONMENT, WITH OR WITHOUT REASONABLE ACCOMMODATION, WITHOUT CAUSING UNDUE HARDSHIP. IN EVALUATING UNDUE HARDSHIP, THE NATURE OF THE ACCOMMODATION AND THE LOCATION OF THE DEPLOYMENT MUST BE CONSIDERED. FURTHER, THE EMPLOYEE'S MEDICAL CONDITION MUST NOT POSE A SUBSTANTIAL RISK OF SIGNIFICANT HARM TO THE EMPLOYEE OR OTHERS WHEN TAKING INTO ACCOUNT THE CONDITIONS OF THE RELEVANT DEPLOYED ENVIRONMENT. SEE REF I. THE FINAL AUTHORITY OF WHO MAY DEPLOY TO THE CENTCOM AOR RESTS WITH THE CENTCOM SURGEON AND/OR THE SERVICE COMPONENT SURGEON'S WAIVER AUTHORITY, NOT THE

INDIVIDUAL'S MEDICAL EVALUATING ENTITY OR DEPLOYING PLATFORM.

15.C.1. MEDICAL FITNESS, INITIAL AND ANNUAL SCREENING.

15.C.1.A. MEDICAL READINESS PROCESSING. THE MEDICAL SECTION OF THE DEPLOYMENT SCREENING SITE MAY PUBLISH GUIDANCE, IAW MOD13 AND SERVICE STANDARDS, TO ASSIST IN DETERMINING MEDICAL DEPLOYMENT FITNESS. DEPLOYING PERSONNEL MUST HAVE AN EVALUATION BY A MEDICAL PROVIDER TO DETERMINE IF THEY CAN SAFELY DEPLOY AND OBTAIN AN APPROVED WAIVER FOR ANY DISQUALIFYING MEDICAL CONDITION(S) FROM THE COMPONENT SURGEON OR CENTCOM SURGEON PRIOR TO DEPLOYING.

15.C.1.B. FITNESS INCLUDES, BUT IS NOT LIMITED TO, THE ABILITY TO ACCOMPLISH ALL REQUIRED TASKS AND DUTIES, BY SERVICE REQUIREMENTS OR DUTY POSITION, CONSIDERING THE ENVIRONMENTAL AND OPERATIONAL CONDITIONS OF THE DEPLOYED LOCATION. AT A MINIMUM, PERSONNEL MUST BE ABLE TO WEAR BALLISTIC, RESPIRATORY, SAFETY, CHEMICAL, AND BIOLOGICAL PERSONAL PROTECTIVE EQUIPMENT; USE REQUIRED PROPHYLACTIC MEDICATIONS; AND INGRESS/EGRESS IN EMERGENCY SITUATIONS WITH MINIMAL RISK TO THEMSELVES OR OTHERS.

15.C.1.C. EXAMINATION INTERVALS. AN EXAMINATION WITH ALL MEDICAL ISSUES AND REQUIREMENTS ADDRESSED WILL REMAIN VALID FOR A MAXIMUM OF 15 MONTHS FROM THE DATE OF THE PHYSICAL, OR 12 MONTHS FOLLOWING DEPLOYMENT, WHICHEVER IS FIRST. SEE TAB A AND REF D, J, K, L AND M FOR FURTHER GUIDANCE. GOVERNMENT CIVILIAN EMPLOYEES, VOLUNTEERS, AND DOD CONTRACTOR PERSONNEL DEPLOYED FOR MULTIPLE OR EXTENDED TOURS OF MORE THAN 12 MONTHS MUST BE RE-EVALUATED FOR FITNESS TO STAY DEPLOYED. ANNUAL IN-THEATER RESCREENING MAY BE FOCUSED ON HEALTH CHANGES, VACCINATION CURRENCY, AND MONITORING OF EXISTING CONDITIONS RATHER THAN BEING COMPREHENSIVE, BUT SHOULD CONTINUE TO MEET ALL MEDICAL GUIDANCE AS PRESCRIBED IN MOD 13. UNLESS SPECIFICALLY OBLIGATED BY CONTRACTUAL ARRANGEMENT, EXPEDITIONARY MILITARY MEDICAL ASSETS ARE NOT TO BE USED FOR RE-EVALUATION TO STAY DEPLOYED. IF INDIVIDUALS ARE UNABLE TO ADEQUATELY COMPLETE THEIR MEDICAL SCREENING EVALUATION IN THE AOR, THEY SHOULD BE REDEPLOYED TO ACCOMPLISH THIS YEARLY REQUIREMENT. PERIODIC HEALTH SURVEILLANCE REQUIREMENTS AND PRESCRIPTION NEEDS ASSESSMENTS SHOULD REMAIN CURRENT THROUGH THE DEPLOYMENT PERIOD.

15.C.1.D. SPECIALIZED GOVERNMENT CIVILIAN EMPLOYEES WHO MUST MEET SPECIFIC PHYSICAL STANDARDS (E.G., FIREFIGHTERS, SECURITY GUARDS, POLICE, AVIATORS, AVIATION CREW MEMBERS, AIR TRAFFIC CONTROLLERS, DIVERS, MARINE CRAFT OPERATORS, COMMERCIAL DRIVERS, ETC.) MUST MEET THOSE STANDARDS WITHOUT EXCEPTION, IN ADDITION TO BEING FOUND FIT FOR THE SPECIFIC DEPLOYMENT BY A MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 13. CERTIFICATIONS MUST REMAIN VALID THROUGHOUT THE ENTIRETY OF THE DEPLOYMENT. IT IS UP TO THE INDIVIDUAL TO PLAN FOR AND RECERTIFY THEIR RESPECTIVE REQUIREMENTS.

15.C.1.E. DOD CONTRACTOR EMPLOYEES MUST MEET SIMILAR STANDARDS OF FITNESS AS MILITARY AND DOD CIVILIAN PERSONNEL, AND MUST BE DOCUMENTED TO BE FIT FOR THE PERFORMANCE OF THEIR DUTIES, WITHOUT LIMITATIONS, BY MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 13. CONTRACTORS MUST COMPLY WITH REF J AND SPECIFICALLY ENCLOSURE 3 FOR MEDICAL REQUIREMENTS. EVALUATIONS SHOULD BE COMPLETED PRIOR TO ARRIVAL AT THE DEPLOYMENT PLATFORM.

15.C.1.E.1. PREDEPLOYMENT AND/OR TRAVEL MEDICINE SERVICES FOR CONTRACTOR EMPLOYEES, INCLUDING COMPLIANCE WITH IMMUNIZATION, DNA, AND PANOGRAPH REQUIREMENTS, EVALUATION OF FITNESS, AND ANNUAL SCREENING ARE THE RESPONSIBILITY OF THE CONTRACTING AGENCY PER THE CONTRACTUAL REQUIREMENTS.

QUESTIONS SHOULD BE SUBMITTED TO THE SUPPORTED COMMAND'S CONTRACTING AND MEDICAL AUTHORITY. SEE TAB A AND REF J FOR FURTHER GUIDANCE.

15.C.1.E.2. ALL CONTRACTING AGENCIES ARE RESPONSIBLE FOR PROVIDING THE APPROPRIATE LEVEL OF MEDICAL SCREENING FOR THEIR EMPLOYEES. SCREENING MUST BE COMPLETED BY A MEDICAL PROVIDER LICENSED IN A COUNTRY WITH OVERSIGHT AND ACCOUNTABILITY OF THE MEDICAL PROFESSION, AND A COPY OF THE COMPLETED MEDICAL SCREENING DOCUMENTATION, IN ENGLISH, MUST BE MAINTAINED BY THE CONTRACTOR. DOCUMENTATION MAY BE REQUESTED BY BASE OPERATIONS CENTER PERSONNEL PRIOR TO ISSUANCE OF ACCESS BADGES AS WELL AS BY MEDICAL PERSONNEL FOR COMPLIANCE REVIEWS. INSTALLATION COMMANDERS, IN CONCERT WITH THEIR LOCAL MEDICAL ASSETS AND CONTRACTING REPRESENTATIVES, MAY CONDUCT QUALITY ASSURANCE AUDITS TO VERIFY THE VALIDITY OF MEDICAL SCREENINGS.

15.C.1.E.3. CONTRACTOR EXPENSE. IAW REF J, CONTRACTORS WILL PROVIDE PREDEPLOYMENT MEDICAL AND DENTAL EVALUATIONS. ANNUAL IN THEATER RESCREENING, IF REQUIRED, WILL BE AT CONTRACTOR EXPENSE. REQUIRED IMMUNIZATIONS OUTLINED IN THE FOREIGN CLEARANCE GUIDE (HTTPS://WWW.FCG.PENTAGON.MIL) FOR THE COUNTRIES TO BE VISITED, AS WELL AS THOSE OUTLINED IN PARAGRAPH 15.F. OF THIS MOD, WILL BE DONE AT CONTRACTOR EXPENSE. THE SOLE EXCEPTION TO THIS POLICY IS ANTHRAX VACCINE, WHICH WILL BE PROVIDED AT MILITARY EXPENSE. SEE REF C, J, AND N. A DISQUALIFYING MEDICAL CONDITION, AS DETERMINED BY AN IN-THEATER COMPETENT MEDICAL AUTHORITY, WILL BE IMMEDIATELY REPORTED TO THE CONTRACTOR EMPLOYEE'S CONTRACTING OFFICER WITH A RECOMMENDATION THAT THE CONTRACTOR BE IMMEDIATELY REDEPLOYED AND REPLACED AT CONTRACTOR EXPENSE UNLESS AN APPROVED WAIVER IS OBTAINED. ALL THE ABOVE EXPENSES WILL BE COVERED BY THE CONTRACTOR UNLESS OTHERWISE SPECIFIED IN THE CONTRACT.

15.C.1.F. LN AND TCN EMPLOYEES. MINIMUM SCREENING REQUIREMENTS INCLUDE:

15.C.1.F.1. PRE-EMPLOYMENT AND ANNUAL MEDICAL SCREENING OF LN AND TCN EMPLOYEES IS NOT TO BE PERFORMED IN MILITARY MTFS. LOCAL CONTRACTING AGENCIES MUST KEEP DOCUMENTATION IAW PARA. 15.C.1.E.1.

15.C.1.F.2. ALL LN AND TCN EMPLOYEES WHOSE JOB REQUIRES CLOSE OR FREQUENT CONTACT WITH NON-LN/TCN PERSONNEL (E.G., DINING FACILITY WORKERS, SECURITY PERSONNEL, INTERPRETERS, ETC.) MUST BE SCREENED FOR TUBERCULOSIS (TB) USING AN ANNUAL SYMPTOM SCREEN. A TUBERCULIN SKIN TEST (TST) IS UNRELIABLE AS A STAND-ALONE SCREENING TEST FOR TB DISEASE IN LN/TCN PERSONNEL AND SHOULD NOT BE USED. SPECIFIC QUESTIONS REGARDING APPROPRIATE SCREENING OF DETAINEES, PRISON GUARDS AND OTHER HIGHER RISK POPULATIONS SHOULD BE REFERRED TO THE THEATER PREVENTIVE MEDICINE CONSULTANT THROUGH UNIT MEDICAL PERSONNEL.

15.C.1.F.3. LN AND TCN EMPLOYEES INVOLVED IN FOOD SERVICE, WATER, AND ICE PRODUCTION MUST BE SCREENED ANNUALLY FOR SIGNS AND SYMPTOMS OF INFECTIOUS DISEASE. CONTRACTORS MUST ENSURE EMPLOYEES RECEIVE TYPHOID AND HEPATITIS A VACCINATIONS AND THIS INFORMATION MUST BE DOCUMENTED IN THE EMPLOYEES' MEDICAL RECORD / SCREENING DOCUMENTATION.

15.C.1.F.4. FURTHER GUIDANCE REGARDING MEDICAL SUITABILITY OR FORCE HEALTH PROTECTION MAY BE PROVIDED BY THE LOCAL TASK FORCE COMMANDER OR EQUIVALENT IN CONSULTATION WITH THEIR MILITARY MEDICAL ASSETS.

15.C.2. UNFIT PERSONNEL. CASES OF IN-THEATER/DEPLOYED PERSONNEL IDENTIFIED AS UNFIT, IAW THIS MOD 13, DUE TO CONDITIONS THAT EXISTED PRIOR TO DEPLOYMENT WILL BE FORWARDED TO THE APPROPRIATE COMPONENT SURGEON FOR DETERMINATION REGARDING POTENTIAL MEDICAL WAIVER OR REDEPLOYMENT. FINDINGS/ACTIONS WILL BE

FORWARDED TO THE CENTCOM SURGEON AT CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL.

15.C.3. MEDICAL WAIVERS.

15.C.3.A. MEDICAL WAIVER APPROVAL AUTHORITY.

15.C.3.A.1. MEDICAL WAIVER APPROVAL AUTHORITY LIES AT THE COMBATANT COMMAND SURGEON LEVEL IAW REF I, O, AND P, AND IS DELEGATED TO THE USCENTCOM COMPONENT SURGEONS FOR ALL DEPLOYING PERSONNEL WITHIN THEIR RESPECTIVE COMPONENT FOR ALL HEALTH CONDITIONS, EXCLUDING BEHAVIORAL HEALTH CONDITIONS. BEHAVIORAL HEALTH WAIVERS WILL INITIALLY BE EVALUATED BY THE RESPECTIVE SERVICE COMPONENT, BUT THE FINAL DETERMINATION FOR APPROVAL RESIDES WITH THE CENTCOM SURGEON. SENDING UNIT COMMANDERS ARE NOT AUTHORIZED TO OVERRIDE A MEDICAL DEPLOYABILITY DETERMINATION, HOWEVER, COMMAND ENDORSEMENT OF SERVICE MEMBER WAIVERS IS REQUIRED PRIOR TO SUBMISSION.

15.C.3.A.2. CONTRACTORS' AND SUB CONTRACTORS' RESPECTIVE SERVICE AFFILIATION IS DETERMINED BY THE 'CONTRACTOR ISSUING AGENCY' BLOCK ON THEIR 'LETTER OF AUTHORIZATION', AND WAIVERS SHOULD BE SENT TO THE APPROPRIATE SERVICE COMPONENT WAIVER AUTHORITY. SEE SECTION 15.C.3.C. THE CENTCOM SURGEON IS THE WAIVER AUTHORITY FOR DOD CIVILIANS, CONTRACTORS, AND ORGANIZATIONS SUCH AS DEFENSE INTELLIGENCE AGENCY, AMERICAN RED CROSS, ETC., WHO ARE NOT DIRECTLY ASSOCIATED WITH A PARTICULAR CENTCOM COMPONENT.

15.C.3.A.3. EXCEPT IN THE CASE OF DOD CIVILIAN EMPLOYEES WHO ARE COVERED BY THE REHABILITATION ACT OF 1973, AN INDIVIDUAL MAY BE DENIED DEPLOYMENT BY THE LOCAL MEDICAL AUTHORITY OR CHAIN OF COMMAND. AN INDIVIDUALIZED ASSESSMENT IS STILL REQUIRED FOR DOD. SEE PARA. 15.C AND REF I. AUTHORITY TO APPROVE DEPLOYMENT OF ANY PERSON (UNIFORMED OR CIVILIAN) WITH DISQUALIFYING MEDICAL CONDITIONS LIES SOLELY WITH THE CENTCOM SURGEON AND THE CENTCOM SERVICE COMPONENT SURGEONS WHO HAVE BEEN DELEGATED THIS AUTHORITY BY THE CENTCOM SURGEON.

15.C.3.A.4. ALL ADJUDICATING SURGEONS WILL MAINTAIN A WAIVER DATABASE AND RECORD ALL WAIVER REQUESTS.

15.C.3.A.5. ADJUDICATION SHOULD ACCOUNT FOR SPECIFIC MEDICAL SUPPORT CAPABILITIES IN THE LOCAL REGION OF THE AOR. THE COMPONENT SURGEON WILL RETURN THE SIGNED WAIVER FORM TO THE REQUEST ORIGINATOR FOR INCLUSION IN THE PATIENT'S DEPLOYMENT MEDICAL RECORD AND THE ELECTRONIC MEDICAL RECORD (EMR).

15.C.3.B. WAIVER PROCESS. IF A MEDICAL WAIVER IS DESIRED, LOCAL MEDICAL PERSONNEL WILL INFORM THE NON-DEPLOYABLE INDIVIDUAL AND THE UNIT COMMAND/SUPERVISOR ABOUT THE WAIVER PROCESS AS FOLLOWS.

15.C.3.B.1. AUTHORIZED AGENTS (LOCAL MEDICAL PROVIDER, COMMANDER/SUPERVISOR, REPRESENTATIVE, OR INDIVIDUAL MEMBER) WILL FORWARD A COMPLETED MEDICAL WAIVER REQUEST FORM (TAB C), TO BE ADJUDICATED BY THE APPROPRIATE SURGEON IAW PARAGRAPH 15.C.3.C. WAIVER SUBMISSION BY OR THROUGH A MEDICAL AUTHORITY IS STRONGLY ENCOURAGED TO AVOID UNNECESSARY ADJUDICATION DELAYS DUE TO INCOMPLETE INFORMATION. UNIFORMED PERSONNEL MUST OBTAIN COMMAND ENDORSEMENT OF THE WAIVER PRIOR TO SUBMISSION. THE CASE SUMMARY PORTION OF THE WAIVER SHOULD INCLUDE A SYNOPSIS OF THE CONCERNING CONDITION(S) AND ALL SUPPORTING DOCUMENTATION TO INCLUDE THE PROVIDER'S ASSESSMENT OF ABILITY TO DEPLOY.

15.C.3.B.2. DISAPPROVALS MUST BE DOCUMENTED AND SHOULD NOT BE GIVEN TELEPHONICALLY.

15.C.3.B.3. A CENTCOM WAIVER DOES NOT PRECLUDE THE NEED FOR SERVICE-SPECIFIC MEDICAL WAIVERS (E.G., SMALL ARMS WAIVERS) OR OCCUPATIONAL MEDICAL WAIVERS (E.G., AVIATORS, COMMERCIAL TRUCK DRIVERS, ETC.) IF REQUIRED.
15.C.3.B.4. APPEAL PROCESS. IF THE SENDING UNIT DISAGREES WITH THE COMPONENT SURGEON'S DECISION, AN APPEAL MAY BE SUBMITTED TO THE CENTCOM SURGEON. IF THE DISAGREEMENT IS WITH THE CENTCOM SURGEON'S DECISION, AN APPEAL MAY BE SUBMITTED THROUGH THE CHAIN OF COMMAND TO THE CENTCOM CHIEF OF STAFF.
15.C.3.B.5. WAIVERS ARE APPROVED FOR A MAXIMUM OF 12 MONTHS OR FOR THE TIMEFRAME SPECIFIED ON THE WAIVER (TAB C). WAIVER COVERAGE BEGINS ON THE DATE OF THE INITIAL DEPLOYMENT AND REMAINS IN EFFECT FOR EITHER THE TIME PERIOD SPECIFIED ON THE WAIVER OR A MAXIMUM TIME OF 12 MONTHS.
15.C.3.B.6. WAIVERS MAY BE APPROVED, AT THE WAIVER AUTHORITY'S SOLE DISCRETION, FOR PERIODS OF TIME (E.G. 90 DAYS) SHORTER THAN THE SCHEDULED DEPLOYMENT DURATION IN ORDER TO REQUIRE REASSESSMENT OF A MEDICAL CONDITION. SUCH WAIVERS WILL INCLUDE RESUBMISSION INSTRUCTIONS. ALL LABS, ASSESSMENTS, ETC. REQUIRED FOR RESUBMISSION ARE THE RESPONSIBILITY OF THE EMPLOYEE TO OBTAIN AND SUBMIT.
15.C.3.C. CONTACTS FOR WAIVERS
15.C.3.C.1. CENTCOM SURGEON. CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL;
CML: 813.529.0361; DSN: 312.529.0361
15.C.3.C.2. AFCENT SURGEON. USCENTAFSG.ORGBOX@AFCENT.AF.MIL;
CML: 803.717.7101; DSN: 313.717.7101
15.C.3.C.3. ARCENT SURGEON. USARMY.SHAW.USARCENT.MBX.SURG-WAIVER@MAIL.MIL;
CML: 803.885.7946; DSN: 312.889.7946
15.C.3.C.4. MARCENT SURGEON. FORCE.SURGEON@MARCENT.USMC.MIL;
CML: 813.827.7175; DSN: 312.651.7175
15.C.3.C.5. NAVCENT SURGEON. CUSNC.MEDWAIVERS@ME.NAVY.MIL;
CML: 011.973.1785.4558; DSN: 318.439.4558
15.C.3.C.6. SOCCENT SURGEON. SOCCENT.SG@SOCCENT.CENTCOM.MIL;
CML: 813.828.4351; DSN: 312.968.4351
15.D. PHARMACY.
15.D.1. SUPPLY. PERSONNEL WHO REQUIRE MEDICATION AND WHO ARE DEPLOYING TO THE CENTCOM AOR WILL DEPLOY WITH NO LESS THAN A 180 DAY SUPPLY (OR APPROPRIATE AMOUNT FOR SHORTER DEPLOYMENTS) OF THEIR MAINTENANCE MEDICATIONS WITH ARRANGEMENTS TO OBTAIN A SUFFICIENT SUPPLY TO COVER THE REMAINDER OF THE DEPLOYMENT USING A FOLLOW-ON REFILL PRESCRIPTION. TRICARE ELIGIBLE PERSONNEL WILL OBTAIN FOLLOW-ON REFILL PRESCRIPTIONS FROM THE TRICARE MAIL ORDER PHARMACY (TMOP) DEPLOYED PRESCRIPTION PROGRAM (DPP) OR EXPRESS SCRIPTS. INFORMATION ON THIS PROGRAM MAY BE FOUND AT HTTPS://WWW.EXPRESS-SCRIPTS.COM/TRICARE/TOOLS/DEPLOYEDRX.SHTML .
15.D.2. EXCEPTIONS. EXCEPTIONS TO THE 180 DAY PRESCRIPTION QUANTITY REQUIREMENT INCLUDE:
15.D.2.A. PERSONNEL REQUIRING MALARIA CHEMOPROPHYLACTIC MEDICATIONS (DOXYCYCLINE, ATOVAQUONE/PROGUANIL, ETC.) WILL DEPLOY WITH EITHER ENOUGH MEDICATION FOR THEIR ENTIRE DEPLOYMENT OR WITH ENOUGH TO COVER APPROXIMATELY HALF OF THE DEPLOYMENT WITH PLANS TO RECEIVE THE REMAINDER OF THEIR MEDICATION IN THEATER (EXCLUDING PRIMAQUINE FOR TERMINAL PROPHYLAXIS) BASED ON UNIT PREFERENCE. UNITS WILL DISTRIBUTE TERMINAL PROPHYLAXIS UPON REDEPLOYMENT. THE DEPLOYMENT PERIOD WILL BE CONSIDERED TO INCLUDE AN ADDITIONAL 28 DAYS AFTER

LEAVING THE MALARIA RISK AREA (FOR DOXYCYCLINE) OR 7 DAYS (FOR MALARONE) TO ACCOUNT FOR REQUIRED PRIMARY PROPHYLAXIS. TERMINAL PROPHYLAXIS WITH PRIMAQUINE FOR 14 DAYS SHOULD BEGIN ONCE THE INDIVIDUAL MEMBER HAS LEFT THE AREA OF MALARIA RISK.

15.D.2.B. PSYCHOTROPIC MEDICATION MAY BE DISPENSED FOR UP TO A 180 DAY SUPPLY WITH NO REFILL.

15.D.2.B.1. IF REQUIRED, THE PROVIDER MAY PRESCRIBE A LIMITED QUANTITY (I.E., AT LEAST A 90 DAY SUPPLY) WITH NO REFILLS TO FACILITATE CLINICAL FOLLOW-UP IN THEATER.

15.D.2.B.2. PSYCHOTROPIC MEDICATIONS AUTHORIZED FOR UP TO A 180 DAYS SUPPLY INCLUDE, BUT ARE NOT LIMITED TO; ANTI-DEPRESSANTS, ANTI-ANXIETY (NON CONTROLLED SUBSTANCES), NON-CLASS 2 (CII) STIMULANTS, AND ANTI-SEIZURE MEDICATIONS USED FOR MOOD DISORDERS. THIS TERM ALSO ENCOMPASSES THE GENERIC EQUIVALENTS OF THE ABOVE MEDICATION CATEGORIES WHEN USED FOR NON-PSYCHOTROPIC INDICATIONS.

15.D.2.C. ALL FDA CONTROLLED SUBSTANCES (SCHEDULE I-V) ARE LIMITED TO A 90 DAY SUPPLY WITH NO REFILLS. AN APPROVED WAIVER MUST BE OBTAINED FROM THE CENTCOM WAIVER AUTHORITY PRIOR TO DEPLOYMENT, AND WILL BE REQUIRED FOR ALL RENEWALS. CLINICAL FOLLOW-UP IN THEATER SHOULD BE SOUGHT AT THE EARLIEST OPPORTUNITY TO OBTAIN MEDICATION RENEWALS.

15.D.3. PRESCRIPTION MEDICATION ANALYSIS AND REPORTING TOOL (PMART). SOLDIER READINESS PROCESSING (SRP) AND OTHER DEPLOYMENT PLATFORM PROVIDER/PHARMACY AND UNIT MEDICAL OFFICER PERSONNEL WILL MAXIMIZE THE USE OF THE PRESCRIPTION MEDICATION ANALYSIS AND REPORTING TOOL (PMART) TO SCREEN DEPLOYING PERSONNEL FOR HIGH-RISK MEDICATIONS, AS WELL AS TO IDENTIFY MEDICATIONS WHICH ARE TEMPERATURE-SENSITIVE, OVER THE COUNTER (FOR SITUATIONAL AWARENESS REGARDING MEDICATION INTERACTION), OR NOT AVAILABLE ON THE CENTCOM FORMULARY AND/OR THROUGH THE TMOP/DPP. CONTACT THE DHA PHARMACY ANALYTICS SUPPORT SECTION AT 1.866.275.4732 OR USARMY.JBSA.MEDCOM-AMEDDCS.MBX.PHARMACOECONOMIC-CENTER@MAIL.MIL FOR INFORMATION ON HOW TO OBTAIN A PMART REPORT. INFORMATION REGARDING PMART AS WELL AS THE CENTCOM FORMULARY CAN BE FOUND AT THE HEALTH.MIL WEBSITE AT: WWW.HEALTH.MIL/PMART.

15.D.4. TRICARE MAIL ORDER PHARMACY (TMOP). PERSONNEL REQUIRING ONGOING PHARMACOTHERAPY WILL MAXIMIZE USE OF THE TMOP/DPP SYSTEM (TO INCLUDE MEDICATIONS LISTED IN 15.D.2.B AND 15.D.2.C) WHEN POSSIBLE. THOSE ELIGIBLE FOR TMOP WILL COMPLETE ON-LINE ENROLLMENT AND REGISTRATION PRIOR TO DEPLOYMENT IF POSSIBLE. INSTRUCTIONS CAN BE FOUND AT HTTPS://WWW.EXPRESS-SCRIPTS.COM/TRICARE/TOOLS/DEPLOYEDRX.SHTML

15.E. MEDICAL EQUIPMENT.

15.E.1. PERMITTED EQUIPMENT. PERSONNEL WHO REQUIRE MEDICAL EQUIPMENT (E.G., CORRECTIVE EYEWEAR, HEARING AIDS) MUST DEPLOY WITH ALL REQUIRED ITEMS IN THEIR POSSESSION TO INCLUDE TWO PAIRS OF EYEGLASSES, PROTECTIVE MASK EYEGLASS INSERTS, BALLISTIC EYEWEAR INSERTS, AND HEARING AID BATTERIES. SEE REF D

15.E.2. NON-PERMITTED EQUIPMENT. PERSONAL DURABLE MEDICAL EQUIPMENT (NEBULIZERS, SCOOTERS, WHEELCHAIRS, CATHETERS, DIALYSIS MACHINES, INSULIN PUMPS, IMPLANTED DEFIBRILLATORS, SPINAL CORD STIMULATORS, CEREBRAL IMPLANTS, ETC.) IS NOT PERMITTED. MEDICAL MAINTENANCE, LOGISTICAL SUPPORT, AND INFECTION CONTROL PROTOCOLS FOR PERSONAL MEDICAL EQUIPMENT ARE NOT AVAILABLE AND ELECTRICITY IS OFTEN UNRELIABLE. A WAIVER FOR A MEDICAL CONDITION REQUIRING PERSONAL DURABLE MEDICAL EQUIPMENT WILL ALSO BE CONSIDERED APPLICABLE TO THE EQUIPMENT. DURABLE MEDICAL EQUIPMENT THAT IS NOT MEDICALLY COMPULSORY BUT USED FOR RELIEF OR

MAINTENANCE OF A MEDICAL CONDITION WILL REQUIRE A WAIVER. WAIVERS SHOULD COMPELLINGLY ARGUE FOR CONTINUED READINESS DESPITE PRESUMED FAILURE OF THE EQUIPMENT. MAINTENANCE AND RESUPPLY OF NON-PERMITTED EQUIPMENT IS THE RESPONSIBILITY OF THE INDIVIDUAL.

15.E.3. CONTACT LENSES.

15.E.3.A. ARMY, NAVY, AND MARINE PERSONNEL WILL NOT DEPLOY WITH CONTACT LENSES EXCEPT IAW SERVICE POLICY.

15.E.3.B. AIR FORCE PERSONNEL (NON-AIRCREW) WILL NOT DEPLOY WITH CONTACT LENSES UNLESS WRITTEN AUTHORIZATION IS PROVIDED BY THE DEPLOYING UNIT COMMANDER. CONTACT LENSES ARE LIFE SUPPORT EQUIPMENT FOR USAF AIRCREWS AND THEREFORE ARE EXEMPT IAW SERVICE GUIDELINES. AIR FORCE PERSONNEL DEPLOYING WITH CONTACT LENSES MUST RECEIVE PRE-DEPLOYMENT EDUCATION IN THE SAFE WEAR AND MAINTENANCE OF CONTACT LENSES IN THE DEPLOYED ENVIRONMENT. THEY MUST ALSO DEPLOY WITH TWO PAIRS OF EYEGLASSES AND A SUPPLY OF CONTACT LENS MAINTENANCE ITEMS (E.G., CLEANSING SOLUTION) ADEQUATE FOR THE DURATION OF THE DEPLOYMENT.

15.E.4. MEDICAL WARNING TAGS. DEPLOYING PERSONNEL REQUIRING MEDICAL WARNING TAGS (MEDICATION ALLERGIES, G6PD DEFICIENCY, DIABETES, SICKLE CELL DISEASE, ETC.) WILL DEPLOY WITH RED MEDICAL WARNING TAGS WORN IN CONJUNCTION WITH THEIR PERSONAL IDENTIFICATION TAGS.

15.E.4.A. MEDICAL PERSONNEL IDENTIFY NEED FOR MEDICAL WARNING TAGS AND PREPARE DOCUMENTATION.

15.E.4.B. INSTALLATION OR ORGANIZATION COMMANDERS WILL DIRECT EMBOSSING ACTIVITIES TO PROVIDE TAGS IAW SERVICE PROCEDURES.

15.F. IMMUNIZATIONS.

15.F.1. ADMINISTRATION. ALL IMMUNIZATIONS WILL BE ADMINISTERED IAW REF Q. REFER TO THE DHA-IMMUNIZATION HEALTHCARE BRANCH WEBSITE HTTP://WWW.HEALTH.MIL/MILITARY-HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR OR CONTACT THE CENTCOM DHA-IMMUNIZATION HEALTHCARE BRANCH ANALYST BRIAN.D.CANTERBURY.CIV@MAIL.MIL FOR QUESTIONS AND CLARIFICATIONS.

15.F.2. REQUIREMENTS. ALL PERSONNEL (TO INCLUDE PCS AND SHIPBOARD PERSONNEL) TRAVELING FOR ANY PERIOD OF TIME TO THE THEATER WILL BE CURRENT WITH ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) IMMUNIZATION GUIDELINES AND SERVICE INDIVIDUAL MEDICAL READINESS (IMR) REQUIREMENTS IAW REF C. CURRENT DOD IMMUNIZATIONS REQUIREMENTS AND RECOMMENDATIONS CAN BE FOUND AT THE DEFENSE HEALTH AGENCY WEBSITE, ON THE CENTCOM TAB, AT HTTP://WWW.HEALTH.MIL/MILITARY-HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR . IN ADDITION, ALL TDY PERSONNEL MUST COMPLY WITH FOREIGN CLEARANCE GUIDELINES FOR THE COUNTRIES TO OR THROUGH WHICH THEY ARE TRAVELING. MANDATORY VACCINES FOR DOD PERSONNEL (MILITARY, CIVILIAN & CONTRACTORS) TRAVELING FOR ANY PERIOD OF TIME IN THEATER ARE:

15.F.2.A. TETANUS/DIPHTHERIA. RECEIVE A ONE-TIME DOSE OF TDAP IF NO PREVIOUS DOSE(S) RECORDED. RECEIVE TETANUS (TD) IF ≥ 10 YEARS SINCE LAST TDAP OR TD BOOSTER.

15.F.2.B. VARICELLA. REQUIRED DOCUMENTATION OF ONE OF THE FOLLOWING: BORN BEFORE 1980 (HEALTH CARE WORKERS MAY NOT USE THIS EXEMPTION), DOCUMENTED PREVIOUS INFECTION (CONFIRMED BY EITHER EPIDEMIOLOGIC LINK OR LABORATORY RESULT), SUFFICIENT VARICELLA TITER, OR DOCUMENTED ADMINISTRATION OF VACCINE (2 DOSES).

15.F.2.C. MEASLES / MUMPS / RUBELLA. REQUIRED DOCUMENTATION OF ONE OF THE FOLLOWING: BORN BEFORE 1957, DOCUMENTATION OF EFFECTIVE IMMUNITY BY TITER, OR DOCUMENTED ADMINISTRATION OF 2 LIFETIME DOSES OF MMR.
15.F.2.D. POLIO. REQUIRED FOR TRAVEL TO/THROUGH **AFGHANISTAN OR PAKISTAN FOR ≥4 WEEKS**.
15.F.2.D.1 BOOSTER DOSE OF EITHER ORAL (OPV) OR INACTIVATED (IPV) VACCINE (IPV IS THE ONLY POLIO VACCINE CURRENTLY AVAILABLE IN THE UNITED STATES) BETWEEN 4 WEEKS AND 12 MONTHS OF DEPARTURE FROM AFGHANISTAN OR PAKISTAN.
15.F.2.D.2. IMMUNIZATION SHOULD BE DOCUMENTED ON THE CDC-731 CERTIFICATE OF VACCINATION OR PROPHYLAXIS (YELLOW SHOT RECORD) IN ADDITION TO THE DD2766C TO MEET INTERNATIONAL STANDARDS.
15.F.2.D.3. MEDICAL ASSUMED (MA) AND MEDICAL IMMUNE (MI) EXEMPTIONS ARE NOT ACCEPTED FOR THIS REQUIREMENT.
15.F.2.D.4. IAW WORLD HEALTH ORGANIZATION (WHO) OR ACIP DISEASE OUTBREAK GUIDANCE, MORE STRINGENT VACCINATION REQUIREMENTS MAY BE RECOMMENDED.
15.F.2.E. SEASONAL INFLUENZA (INCLUDING EVENT-SPECIFIC INFLUENZA, E.G., H1N1).
15.F.2.F. HEPATITIS A. AT LEAST ONE DOSE PRIOR TO DEPLOYMENT WITH SUBSEQUENT COMPLETION OF SERIES IN THEATER.
15.F.2.G. HEPATITIS B. AT LEAST ONE DOSE PRIOR TO DEPLOYMENT WITH SUBSEQUENT COMPLETION OF SERIES IN THEATER.
15.F.2.H. TYPHOID. BOOSTER DOSE OF TYPHIM VI VACCINE IF GREATER THAN TWO YEARS SINCE LAST VACCINATION WITH INACTIVATED / INJECTABLE VACCINE OR GREATER THAN FIVE YEARS SINCE RECEIPT OF LIVE / ORAL VACCINE. ORAL VACCINE IS AN ACCEPTABLE OPTION ONLY IF TIME ALLOWS FOR RECEIPT AND COMPLETION OF ALL FOUR DOSES PRIOR TO DEPLOYMENT.
15.F.3. ANTHRAX. PERSONNEL WITHOUT A MEDICAL CONTRAINDICATION TRAVELING IN THE CENTCOM THEATER FOR 15 DAYS OR MORE WILL COMPLY WITH THE MOST CURRENT DOD ANTHRAX REQUIREMENTS, CURRENTLY A SERIES OF 5 VACCINES AND ANNUAL BOOSTER. SEE REF N, R, AND S AND EXCEPTIONS FOR VACCINATION IN 15.F.6.
15.F.3.A. MILITARY PERSONNEL. REQUIRED.
15.F.3.B. DOD CIVILIANS. REQUIRED AT GOVERNMENT EXPENSE, FOR EMERGENCY ESSENTIAL PERSONNEL IAW REF N.
15.F.3.C. DOD CONTRACTORS. REQUIRED AT GOVERNMENT EXPENSE AS DIRECTED IN THE CONTRACT.
15.F.3.D. VOLUNTEERS. VOLUNTARY AT GOVERNMENT EXPENSE.
15.F.4. SMALLPOX. AS OF 16 MAY 2014, SMALLPOX VACCINATION IS NO LONGER REQUIRED FOR THE CENTCOM AOR. SEE REF R.
15.F.5. RABIES. PRE-EXPOSURE VACCINATION SHOULD BE ACCOMPLISHED AS BELOW, OR OTHERWISE CONSIDERED FOR PERSONNEL WHO ARE NOT REASONABLY EXPECTED TO RECEIVE PROMPT MEDICAL EVALUATION AND RISK-BASED RABIES POST-EXPOSURE PROPHYLAXIS WITHIN 72 HOURS OF EXPOSURE TO A POTENTIALLY RABID ANIMAL. FOR ALREADY-VACCINATED PERSONNEL, BOOSTER DOSES ARE REQUIRED EVERY TWO YEARS OR WHEN TITERS INDICATE. EXCEPTIONS MAY BE IDENTIFIED BY UNIT SURGEONS.
15.F.5.A. HIGH RISK PERSONNEL: PRE-EXPOSURE VACCINATION IS REQUIRED FOR VETERINARY PERSONNEL, MILITARY WORKING DOG HANDLERS, ANIMAL CONTROL PERSONNEL, CERTAIN SECURITY PERSONNEL, CIVIL ENGINEERS AT RISK OF EXPOSURE TO RABID ANIMALS, AND LABORATORY PERSONNEL WHO WORK WITH RABIES SUSPECT SAMPLES.

15.F.5.B. SPECIAL OPERATIONS FORCES (SOF)/SOF ENABLERS: ALL PERSONNEL DEPLOYING IN SUPPORT OF SOF WILL BE ADMINISTERED THE PRE-EXPOSURE RABIES VACCINE SERIES AS INDICATED BELOW.
15.F.5.B.1. AFGHANISTAN. PERSONNEL WITH PRIMARY DUTIES OUTSIDE OF FIXED BASES.
15.F.5.B.2. PAKISTAN. ALL PERSONNEL.
15.F.5.B.3. OTHER AREAS. PER USSOCOM SERVICE-SPECIFIC POLICIES. CONTACT USSOCOM PREVENTIVE MEDICINE OFFICER AT DSN (312) 299-5051 FOR MORE INFORMATION.
15.F.6. EXCEPTIONS. REQUIRED IMMUNIZATIONS WILL BE ADMINISTERED PRIOR TO DEPLOYMENT, WITH THE FOLLOWING POSSIBLE EXCEPTIONS:
15.F.6.A. THE FIRST VACCINE IN A REQUIRED SERIES MUST BE ADMINISTERED PRIOR TO DEPLOYMENT WITH ARRANGEMENTS MADE FOR SUBSEQUENT IMMUNIZATIONS TO BE GIVEN IN THEATER.
15.F.6.B. IAW REF S, ANTHRAX MAY BE ADMINISTERED UP TO 120 DAYS PRIOR TO DEPLOYMENT. IT IS HIGHLY ADVISABLE TO GET THE FIRST TWO ANTHRAX IMMUNIZATIONS OR SUBSEQUENT DOSE/BOOSTER PRIOR TO DEPLOYMENT IN ORDER TO AVOID UNNECESSARY STRAIN ON THE DEPLOYED HEALTHCARE SYSTEM.
15.F.7. ADVERSE MEDICAL EVENTS RELATED TO IMMUNIZATIONS SHOULD BE REPORTED THROUGH REPORTABLE MEDICAL EVENTS (RME) IF CASE DEFINITIONS ARE MET. ALL IMMUNIZATION RELATED UNEXPECTED ADVERSE EVENTS ARE TO BE REPORTED THROUGH THE VACCINE ADVERSE EVENTS REPORTING SYSTEM (VAERS) AT HTTP://WWW.VAERS.HHS.GOV.
15.F.8. USCENTCOM AND COMPONENTS WILL MONITOR IMMUNIZATION COMPLIANCE VIA THE COCOM IMMUNIZATION REPORTING DATABASE. SUBORDINATE COMMANDS WILL REQUEST ACCESS TO THE COCOM IMMUNIZATION REPORTING DATABASE BY CONTACTING CCSG AT BRIAN.CANTERBURY2@CENTCOM.MIL OR CCSG-PMO@CENTCOM.SMIL.MIL.
15.G. MEDICAL / LABORATORY TESTING.
15.G.1. HIV TESTING. HIV LAB TESTING, WITH DOCUMENTED NEGATIVE RESULT, WILL BE WITHIN 120 DAYS PRIOR TO DEPLOYMENT OR DEPARTURE FOR ANY REQUIRED DEPLOYMENT TRAINING IF TRAINING IS EN ROUTE TO DEPLOYMENT LOCATION. IAW REF I AND T, THE COGNIZANT COMBATANT COMMAND SURGEON SHALL BE DIRECTLY CONSULTED IN ALL INSTANCES OF HIV SEROPOSITIVITY BEFORE MEDICAL CLEARANCE FOR DEPLOYMENT.
15.G.2. SERUM SAMPLE. SAMPLE WILL BE TAKEN WITHIN THE PREVIOUS 365 DAYS. IF THE INDIVIDUAL'S HEALTH STATUS HAS RECENTLY CHANGED OR HAS HAD AN ALTERATION IN OCCUPATIONAL EXPOSURES THAT INCREASES HEALTH RISKS, A HEALTH CARE PROVIDER MAY CHOOSE TO HAVE A SPECIMEN DRAWN CLOSER TO THE ACTUAL DATE OF DEPLOYMENT. SEE REF U.
15.G.3. G6PD TESTING. DOCUMENTATION OF ONE-TIME GLUCOSE-6-PHOSPHATE DEHYDROGENASE (G6PD) DEFICIENCY TESTING IS IAW REF V. ENSURE RESULT IS IN MEDICAL RECORD OR DRAW PRIOR TO DEPARTURE. PRE-DEPLOYMENT MEDICAL SCREENERS WILL RECORD THE RESULT OF THIS TEST IN THE SERVICE MEMBER'S PERMANENT MEDICAL RECORD, DEPLOYMENT MEDICAL RECORD (DD FORM 2766) AND SERVICE SPECIFIC ELECTRONIC MEDICAL RECORD. (REF V) IF AN INDIVIDUAL IS FOUND TO BE G6PD-DEFICIENT, THEY SHOULD BE ISSUED MEDICAL WARNING TAGS (SEE 15.E.4.) THAT STATE "G6PD DEFICIENT: NO PRIMAQUINE". IF PRIMAQUINE IS GOING TO BE ISSUED TO A DOD CIVILIAN OR DOD CONTRACTOR, COMPLETE THE TESTING AT GOVERNMENT EXPENSE.
15.G.4. HCG. REQUIRED WITHIN 30 DAYS OF DEPLOYMENT FOR ALL WOMEN, AS WELL THOSE FEMALE TO MALE TRANSGENDERED INDIVIDUALS WHO HAVE RETAINED FEMALE ANATOMY. ABOVE INDIVIDUALS WITH A DOCUMENTED HISTORY OF A HYSTERECTOMY ARE EXEMPT. PREGNANCY WILL BE RULED OUT PRIOR TO ANY IMMUNIZATION (EXCEPT INFLUENZA) AND

MEDICAL CLEARANCE FOR DEPLOYMENT.

15.G.5. DNA SAMPLE. REQUIRED FOR ALL DOD PERSONNEL, INCLUDING CIVILIANS AND CONTRACTORS. OBTAIN SAMPLE OR CONFIRM SAMPLE IS ON FILE BY CONTACTING THE DOD DNA SPECIMEN REPOSITORY (COMM: 301.319.0366, DSN: 285; FAX 301.319.0369); HTTP://WWW.AFMES.MIL . SEE REF C, D, AND W.

15.G.6. TUBERCULOSIS (TB) TESTING. SEE REF X.

15.G.6.A. TUBERCULOSIS TESTING FOR SERVICE MEMBERS WILL BE PERFORMED AND DOCUMENTED IAW SERVICE POLICY. CURRENT POLICY IS TO AVOID UNIVERSAL TESTING, AND INSTEAD USE TARGETED TESTING BASED UPON RISK ASSESSMENT, USUALLY PERFORMED WITH A SIMPLE QUESTIONNAIRE. DEPLOYMENT TO TB ENDEMIC COUNTRIES, EVEN FOR PERIODS IN EXCESS OF A YEAR, HAS NOT BEEN SHOWN TO BE A RISK FACTOR FOR TB FOR MOST AVERAGE-RISK SERVICE MEMBERS. TB TESTING FOR DOD CIVILIANS, CONTRACTORS, VOLUNTEERS, AND OTHER PERSONNEL SHOULD BE SIMILARLY TARGETED IAW CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES, WITH TESTING FOR TB TO BE ACCOMPLISHED WITHIN 90 DAYS OF DEPLOYMENT IF INDICATED. IF TESTING IS PERFORMED TUBERCULIN SKIN TEST (TST) OR AN INTERFERON-GAMMA RELEASE ASSAY MAY BE USED UNLESS OTHERWISE INDICATED.

15.G.6.B. POSITIVE TB TESTS WILL BE HANDLED IAW SERVICE POLICY AND CDC GUIDELINES. PERSONNEL WITH A POSITIVE TB TEST SHOULD BE EVALUATED AND COUNSELED. EVALUATION WILL INCLUDE AT LEAST A SYMPTOM QUESTIONNAIRE FOR ACTIVE TB DISEASE, EXPOSURE HISTORY, AND CHEST X-RAY.

15.G.6.C. THE DECISION TO TREAT LTBI IN U.S. FORCES AND CIVILIANS DURING DEPLOYMENT INSTEAD OF AFTER REDEPLOYMENT SHOULD INCLUDE CONSIDERATION OF THE RISKS AND BENEFITS OF TREATMENT DURING DEPLOYMENT, INCLUDING: RISK OF TB ACTIVATION, RISK OF ADVERSE EVENTS FROM LTBI TREATMENT, TIME REMAINING IN DEPLOYMENT, AVAILABILITY OF MEDICAL PERSONNEL TRAINED IN LTBI TREATMENT, AVAILABILITY OF FOLLOW-UP DURING TREATMENT, AND AVAILABILITY OF MEDICATION. LACK OF TREATMENT FOR LTBI IS NOT A CONTRAINDICATION FOR DEPLOYMENT INTO THE CENTCOM AOR AND NO WAIVERS ARE REQUIRED FOR A DIAGNOSIS OF LTBI IF APPROPRIATE EVALUATION AND COUNSELING, AS NOTED ABOVE, IS COMPLETED.

15.G.6.D. UNIT-BASED / LARGE GROUP OR INDIVIDUAL LTBI TESTING SHOULD NOT BE PERFORMED IN THE AOR EXCEPT AMONG CLOSE CONTACTS OF CASES OF KNOWN TB DISEASE.

15.G.6.E. U.S. FORCES AND DOD CIVILIANS WITH TB DISEASE WILL BE EVACUATED FROM THEATER FOR DEFINITIVE TREATMENT. EVALUATION AND TREATMENT OF TB AMONG U.S. CONTRACTORS, LOCAL NATIONALS (LN) AND THIRD COUNTRY NATIONAL (TCN) EMPLOYEES WILL BE AT CONTRACTOR EXPENSE. EMPLOYEES WITH SUSPECTED OR CONFIRMED PULMONARY TB DISEASE WILL BE EXCLUDED FROM WORK UNTIL CLEARED BY THE THEATER PREVENTIVE MEDICINE CONSULTANT FOR RETURN TO WORK.

15.G.7. OTHER LABORATORY TESTING. OTHER TESTING MAY BE PERFORMED AT THE CLINICIAN'S DISCRETION COMMENSURATE WITH RULING OUT OR MONITORING NON-DEPLOYABLE CONDITIONS AND ENSURING PERSONNEL MEET STANDARDS OF FITNESS IAW PARAGRAPH 15.C.2.

15.H. HEALTH ASSESSMENTS.

15.H.1. HEALTH ASSESSMENTS AND EXAMS. PERIODIC HEALTH ASSESSMENTS MUST BE CURRENT IAW SERVICE POLICY AT TIME OF DEPLOYMENT AND SPECIAL DUTY EXAMS MUST BE CURRENT FOR THE DURATION OF TRAVEL OR DEPLOYMENT PERIOD. SEE REF D, J.

15.H.2. PRE-DEPLOYMENT HEALTH ASSESSMENT (DD FORM 2795).

15.H.2.A. ALL DOD PERSONNEL (MILITARY, CIVILIAN, CONTRACTOR) TRAVELING TO THE

THEATER FOR MORE THAN 30 DAYS WILL COMPLETE OR CONFIRM AS CURRENT A PRE-DEPLOYMENT HEALTH ASSESSMENT WITHIN 120 DAYS OF THE EXPECTED DEPLOYMENT DATE IAW REF Y. THIS ASSESSMENT WILL BE COMPLETED ON A DD FORM 2795 IAW REF C. THIS DOES NOT APPLY TO PCS PERSONNEL, SHIPBOARD PERSONNEL, OR PERSONNEL LOCATED WITH A DHP FUNDED FIXED MEDICAL TREATMENT FACILITY (E.G. BAHRAIN) IAW REF C.

15.H.2.A.1. PERSONNEL TRAVELING TO THE THEATER FOR 15 TO 30 DAYS MAY CONSIDER COMPLETING A PRE-DEPLOYMENT HEALTH ASSESSMENT IN ORDER TO DOCUMENT THEIR HEALTH STATUS AND ADDRESS ANY HEALTH CONCERNS PRIOR TO TRAVEL TO THEATER. THIS IS ESPECIALLY RELEVANT TO THOSE WHOSE POSITION REQUIRES FREQUENT TRAVEL TO THE AOR. THESE INDIVIDUALS ARE ENCOURAGED TO COMPLETE AT LEAST ONE PRE-DEPLOYMENT HEALTH ASSESSMENT EACH YEAR, ALONG WITH A CORRESPONDING POST-DEPLOYMENT HEALTH ASSESSMENT FOR THE SAME YEAR.

15.H.2.B. FOLLOWING COMPLETION OF THE DEPLOYER PORTION OF THE DD FORM 2795, THE DEPLOYER WILL HAVE A PERSON-TO-PERSON DIALOGUE WITH A TRAINED AND CERTIFIED HEALTH CARE PROVIDER (PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, ADVANCED PRACTICE NURSE, INDEPENDENT DUTY CORPSMAN, SPECIAL FORCES MEDICAL SERGEANT, INDEPENDENT DUTY MEDICAL TECHNICIAN, OR INDEPENDENT HEALTH SERVICES TECHNICIAN) TO COMPLETE THE ASSESSMENT.

15.H.2.C. THE COMPLETED ORIGINAL DD FORM 2795 WILL BE PLACED IN THE DEPLOYER'S PERMANENT MEDICAL RECORD, A PAPER COPY IN THE DEPLOYMENT MEDICAL RECORD (DD FORM 2766), AND AN ELECTRONIC COPY TRANSMITTED TO THE DEFENSE MEDICAL SURVEILLANCE SYSTEM (DMSS) AT THE ARMED FORCES HEALTH SURVEILLANCE CENTER (AFHSC). CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2795; A PAPER VERSION WILL SUFFICE.

15.H.3. AUTOMATED NEUROPSYCHOLOGICAL ASSESSMENT METRIC (ANAM).

ALL SERVICE MEMBERS AS DESIGNATED IN REF Z WILL UNDERGO ANAM TESTING WITHIN 12 MONTHS PRIOR TO DEPLOYMENT. ANAM TESTING WILL BE RECORDED IN APPROPRIATE SERVICE DATABASE AND ELECTRONIC MEDICAL RECORD. CONTRACTORS, PCS AND SHIPBOARD PERSONNEL ARE NOT REQUIRED TO UNDERGO ANAM TESTING.

15.H.4. POST-DEPLOYMENT HEALTH ASSESSMENT (DD FORM 2796).

15.H.4.A. ALL PERSONNEL WHO WERE REQUIRED TO COMPLETE A PRE-DEPLOYMENT HEALTH ASSESSMENT WILL COMPLETE A POST-DEPLOYMENT HEALTH ASSESSMENT ON A DD FORM 2796. THE POST-DEPLOYMENT HEALTH ASSESSMENT MUST BE COMPLETED NO EARLIER THAN 30 DAYS BEFORE EXPECTED REDEPLOYMENT DATE AND NO LATER THAN 30 DAYS AFTER REDEPLOYMENT.

15.H.4.A.1. INDIVIDUALS WHO WERE NOT REQUIRED TO COMPLETE A PRE-DEPLOYMENT HEALTH ASSESSMENT, BUT WHO COMPLETED ONE TO COVER MULTIPLE TRIPS TO THEATER EACH OF 30 DAYS OR LESS DURATION, SHOULD COMPLETE A POST-DEPLOYMENT HEALTH ASSESSMENT AT LEAST ONCE A YEAR TO DOCUMENT ANY POTENTIAL EXPOSURES OF CONCERN RESULTING FROM ANY SUCH TRAVEL AND THE POTENTIAL NEED FOR MEDICAL FOLLOW-UP.

15.H.4.A.2. INDIVIDUALS WHO WERE NOT REQUIRED TO COMPLETE A PRE-DEPLOYMENT HEALTH ASSESSMENT MAY BE REQUIRED (BY THE COMBATANT COMMANDER, SERVICE COMPONENT COMMANDER, OR COMMANDER EXERCISING OPERATIONAL CONTROL) TO COMPLETE A POST-DEPLOYMENT HEALTH ASSESSMENT IF ANY HEALTH THREATS EVOLVED OR OCCUPATIONAL AND/OR CBRN EXPOSURES OCCURRED DURING THE DEPLOYMENT THAT WARRANT MEDICAL ASSESSMENT OR FOLLOW-UP. (SEE REF C).

15.H.4.B. ALL REDEPLOYING PERSONNEL WILL UNDERGO A PERSON-TO-PERSON HEALTH ASSESSMENT WITH AN INDEPENDENT PRACTITIONER. THE ORIGINAL COMPLETED COPY OF

THE DD FORM 2796 MUST BE PLACED IN THE INDIVIDUAL'S MEDICAL RECORD AND TRANSMIT AN ELECTRONIC COPY TO THE DMSS AT THE AFHSC. CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2796; A PAPER VERSION WILL SUFFICE.

15.H.5. MENTAL HEALTH ASSESSMENT. ALL SERVICE MEMBERS WILL UNDERGO A PERSON-TO-PERSON MENTAL HEALTH ASSESSMENT WITH A LICENSED MENTAL HEALTH PROFESSIONAL OR TRAINED AND CERTIFIED HEALTH CARE PERSONNEL (SPECIFICALLY A PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, ADVANCED PRACTICE NURSE, INDEPENDENT DUTY CORPSMAN, SPECIAL FORCES MEDICAL SERGEANT, INDEPENDENT DUTY MEDICAL TECHNICIAN, OR INDEPENDENT HEALTH SERVICES TECHNICIAN). ASSESSMENTS WILL BE ACCOMPLISHED WITHIN 120 DAYS PRIOR TO DEPLOYMENT, ONCE DURING EACH 180-DAY PERIOD DURING WHICH A MEMBER IS DEPLOYED (IN-THEATER MENTAL HEALTH ASSESSMENT), AND AFTER REDEPLOYMENT WITHIN 3 TIMEFRAMES (3-6, 7-18, AND 18-30 MONTHS AFTER REDEPLOYMENT), OR AS REQUIRED BY SERVICE POLICY. ASSESSMENTS WILL BE ADMINISTERED AT LEAST 90 DAYS APART. CURRENTLY ADMINISTERED PERIODIC AND OTHER PERSON-TO-PERSON HEALTH ASSESSMENTS, SUCH AS THE POST-DEPLOYMENT HEALTH REASSESSMENT, WILL MEET THE TIME REQUIREMENTS IF THEY CONTAIN ALL PSYCHOLOGICAL AND SOCIAL QUESTIONS IAW REF AA.

15.H.5.A. IN-THEATER MENTAL HEALTH ASSESSMENTS WILL BE CONDUCTED BY PERSONNEL IN DEPLOYED UNITS WHOSE RESPONSIBILITIES INCLUDE PROVIDING UNIT HEALTH CARE SERVICES IF SUCH PERSONNEL ARE AVAILABLE AND THE USE OF SUCH PERSONNEL FOR THE ASSESSMENTS WOULD NOT IMPAIR THE CAPACITY OF SUCH PERSONNEL TO PERFORM HIGHER PRIORITY TASKS.

15.H.5.A.1. PERSONNEL CONDUCTING ASSESSMENTS MUST MEET REQUIREMENTS IN PARAGRAPH 15.H.5.

15.H.5.A.2. SCHEDULING IN-THEATER MENTAL HEALTH ASSESSMENTS MUST BE MADE IN CONSIDERATION OF AND SEEK TO LESSEN POTENTIAL IMPACTS ON THE OPERATIONAL MISSION.

15.H.5.B. MENTAL HEALTH ASSESSMENT GUIDANCE DOES NOT DIRECTLY APPLY TO DOD CONTRACTORS UNLESS SPECIFIED IN THE CONTRACT OR THERE IS A CONCERN FOR A MENTAL HEALTH ISSUE. ALL RELATED MENTAL HEALTH EVALUATIONS WILL BE AT THE CONTRACTOR'S EXPENSE.

15.H.6. POST-DEPLOYMENT HEALTH RE-ASSESSMENT (DD FORM 2900). ALL PERSONNEL WHO WERE REQUIRED TO COMPLETE A PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENT WILL COMPLETE A POST-DEPLOYMENT HEALTH REASSESSMENT (DD FORM 2900) 90 TO 180 DAYS AFTER RETURN TO HOME STATION. SEE WWW.PDHEALTH.MIL FOR ADDITIONAL INFORMATION ON PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENTS. CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2900; A PAPER VERSION WILL SUFFICE.

15.I. MEDICAL RECORD. SEE REF C.

15.I.1. DEPLOYED MEDICAL RECORD. THE DD FORM 2766, ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET, OR EQUIVALENT, WILL BE USED INSTEAD OF DEPLOYING AN INDIVIDUAL'S ENTIRE MEDICAL RECORD. THE DEPLOYED DD FORM 2766 SHOULD BE RE-INTEGRATED INTO THE MAIN MEDICAL RECORD AS PART OF THE REDEPLOYMENT PROCESS.

15.I.1.A. DEPLOYED PERSONNEL (MORE THAN 30 DAYS). DD2766 IS REQUIRED.

15.I.1.B. TDY PERSONNEL (15 – 30 DAYS). DD FORM 2766 IS HIGHLY ENCOURAGED, ESPECIALLY FOR THOSE WHO TRAVEL FREQUENTLY TO THEATER, TO DOCUMENT THEATER-SPECIFIC VACCINES AND CHEMOPROPHYLAXIS, AS REQUIRED.

15.I.1.C. TDY PERSONNEL (LESS THAN 15 DAYS). DD2766 IS NOT REQUIRED.

15.I.1.D. PCS PERSONNEL. FOLLOW SERVICE GUIDELINES FOR MEDICAL RECORD MANAGEMENT.

15.I.2. MEDICAL INFORMATION. THE FOLLOWING HEALTH INFORMATION MUST BE PART OF AN ACCESSIBLE ELECTRONIC MEDICAL RECORD FOR ALL PERSONNEL (SERVICE MEMBERS, CIVILIANS AND CONTRACTORS), OR BE HAND-CARRIED AS PART OF A DEPLOYED MEDICAL RECORD:
15.I.2.A. ANNOTATION OF BLOOD TYPE AND RH FACTOR, G6PD, HIV, AND DNA.
15.I.2.B. CURRENT MEDICATIONS AND ALLERGIES. INCLUDE ANY FORCE HEALTH PROTECTION PRESCRIPTION PRODUCT (FHPPP) PRESCRIBED AND DISPENSED TO AN INDIVIDUAL.
15.I.2.C. SPECIAL DUTY QUALIFICATIONS.
15.I.2.D. ANNOTATION OF CORRECTIVE LENS PRESCRIPTION.
15.I.2.E. SUMMARY SHEET OF CURRENT AND PAST MEDICAL AND SURGICAL CONDITIONS.
15.I.2.F. MOST RECENT DD FORM 2795, PREDEPLOYMENT HEALTH ASSESSMENT.
15.I.2.G. DOCUMENTATION OF DENTAL STATUS CLASSES I OR CLASS II.
15.I.2.H. IMMUNIZATION RECORD. MEDICAL DEPLOYMENT SITES WILL ENTER IMMUNIZATION DATA INTO SERVICE ELECTRONIC TRACKING SYSTEMS, (ARMY-MEDPROS, AIR FORCE-AFCITA, COAST GUARD-MRRS, NAVY-MRRS (ASHORE) OR SAMS (AFLOAT) AND MARINE CORPS-MRRS).
15.I.2.I. ALL APPROVED MEDICAL WAIVERS.
15.J. PRE-DEPLOYMENT TRAINING. SEE REF C.
15.J.1. SCOPE. GENERAL ISSUES TO BE ADDRESSED. INFORMATION REGARDING KNOWN AND SUSPECTED HEALTH RISKS AND EXPOSURES, HEALTH RISK COUNTERMEASURES AND THEIR PROPER EMPLOYMENT, PLANNED ENVIRONMENTAL AND OCCUPATIONAL SURVEILLANCE MONITORING, AND THE OVERALL OPERATIONAL RISK MANAGEMENT PROGRAM.
15.J.2. CONTENT. SHOULD INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING AREAS: COMBAT/OPERATIONAL STRESS CONTROL AND RESILIENCE; POST-TRAUMATIC STRESS AND SUICIDE PREVENTION; MILD TRAUMATIC BRAIN INJURY RISK, IDENTIFICATION AND TRACKING; NUCLEAR, BIOLOGICAL, CHEMICAL THREATS; ENDEMIC PLANT, ANIMAL, REPTILE AND INSECT HAZARDS AND INFECTIONS; COMMUNICABLE DISEASES; VECTORBORNE DISEASES; ENVIRONMENTAL CONDITIONS; SAFETY; OCCUPATIONAL HEALTH.
15.K. MEDICAL CBRN DEFENSE MATERIEL (MCDM) / CHEMICAL BIOLOGICAL RADIOLOGICAL NUCLEAR (CBRN) RESPONSE.
15.K.1. MCDM ITEMS. CJTF-OIR, USFOR-A, AND USCENTCOM SERVICE COMPONENT COMMANDS WILL DETERMINE MCDM AVAILABILITY REQUIREMENTS, BASED UPON BEST ESTIMATES OF RISK AND COMMAND POLICY, FOR ALL FORCES THAT FALL UNDER THEIR RESPECTIVE FORCE PROTECTION AUTHORITIES AS IDENTIFIED IN ANNEX J OF USCENTCOM OPORD 05-02, IN THE FOLLOWING MINIMUM ESSENTIAL QUANTITIES. CONTRACTORS WILL RECEIVE THESE ITEMS PER THEIR CONTRACT.
15.K.1.A. ANTIDOTE TREATMENT NERVE AGENT AUTOINJECTOR (ATNAA) (6505-01-362-7427); RECOMMEND THREE EACH PER AFFECTED INDIVIDUAL.
15.K.1.B. DIAZEPAM INJECTION (CONVULSANT ANTIDOTE NERVE AGENT - CANA) (6505-01-274-0951); RECOMMEND ONE EACH PER AFFECTED INDIVIDUAL.
15.K.1.C. M291A SKIN DECONTAMINATION KIT OR REACTIVE SKIN DECONTAMINATION LOTION (RSDL). RECOMMEND ONE M291A KIT OR ONE POUCH CONTAINING 3 PACKETS OF RSDL PER AFFECTED INDIVIDUAL.
15.K.1.D. CIPROFLOXACIN 500MG TABS OR DOXYCYCLINE 100MG TABS; RECOMMEND SIX TABS (BLISTER PACKS PREFERABLE) PER AFFECTED INDIVIDUAL OF EITHER MEDICATION.TO COVER INITIAL DOSAGE AND SUPPORT PROPHYLAXIS AND/OR TREATMENT FOR THREE DAYS PER INDIVIDUAL. AVAILABILITY OF COMPLETE 30-DAY COURSE OF MEDICATION (60 TABLETS) SHOULD BE CONSIDERED GIVEN MISSION REQUIREMENTS. INDIVIDUALS USING DOXYCYCLINE FOR MALARIA PROPHYLAXIS MAY BE CONSIDERED TO BE COVERED FOR THESE REMAINING DOSES.

15.K.1.E. INDIVIDUAL DEPLOYERS RECEIVING MCDM MEDICATIONS AND/OR EQUIPMENT DURING PRE-DEPLOYMENT PROCESSING SHOULD TURN IN THESE ITEMS TO THEIR UNIT UPON ARRIVAL IN THE AOR.

15.K.2. CBRN COUNTERMEASURES.

15.K.2.A. TO PROTECT AGAINST POSSIBLE AND POTENTIALLY INDICATED CBRN THREATS WITHIN THE AOR, SERVICE COMPONENTS WILL BPT ACQUIRE AND ISSUE, IAW SERVICE POLICY OR ON ORDER FROM THE CENTCOM COMMANDER, THE FOLLOWING TYPES AND QUANTITIES OF MCDM ITEMS FOR THEIR IN-THEATER FORCES.

15.K.2.B. PYRIDOSTIGMINE BROMIDE (PB) 30MG TABS (SOMAN NERVE AGENT PRETREATMENT PYRIDOSTIGMINE - SNAPP); 42 TABLETS PER AFFECTED INDIVIDUAL.

15.K.2.B.1. POTASSIUM IODIDE (KI) TABLETS (FOR BETA/GAMMA RADIATION EXPOSURE); 14 TABS PER AFFECTED INDIVIDUAL.

15.K.2.B.2. SERVICE COMPONENTS AND/OR JTFS WITH BASE OPERATING SUPPORT (BOS) RESPONSIBILITY FOR BASES IN THEATER THAT ARE KEY TRANSPORTATION AND SUPPORT NODES WILL ENSURE ADEQUATE AMOUNTS OF THE MCDM ITEMS LISTED IN PARAGRAPH 15.K. ARE PRE-POSITIONED AND STORED TO SUPPORT THE TRANSIENT POPULATION (NON DEPLOYERS, PCS PERSONNEL, ETC.) THAT MAY RESIDE OR BE PRESENT AT THESE LOCATIONS FOR ANY PERIOD OF TIME AND ANY INDIVIDUAL DEPLOYERS NOT ATTACHED TO A TROOP UNIT MOVEMENT.

15.L. THEATER FORCE HEALTH PROTECTION.

15.L.1. DISEASE RISK ASSESSMENT.

15.L.1.A. MALARIA RISK ASSESSMENT AND GUIDELINES. IN THE ABSENCE OF A LOCAL RISK ASSESSMENT CONDUCTED IAW THE GUIDANCE PROVIDED IN PARAGRAPH 15.L.1.B., THE FOLLOWING COUNTRIES AND TIMEFRAMES REQUIRE CHEMOPROPHYLAXIS. THESE ARE MINIMUM REQUIREMENTS.

15.L.1.A.1. AFGHANISTAN: YEAR ROUND.

15.L.1.A.2. PAKISTAN: YEAR ROUND.

15.L.1.A.3. TAJIKISTAN: APRIL THROUGH OCTOBER.

15.L.1.A.4. YEMEN: YEAR ROUND.

15.L.1.B. LOCAL COMPONENT/JTF SURGEONS ARE ENCOURAGED TO CONDUCT EVIDENCE-BASED ENTOMOLOGICAL AND EPIDEMIOLOGICAL ASSESSMENTS OF MALARIA RISK AT FIXED BASES WHERE SIGNIFICANT NUMBERS OF PERSONNEL ARE ASSIGNED FOR PROLONGED PERIODS. IN CONDUCTING SUCH A RISK ASSESSMENT, SURGEONS SHOULD REVIEW THE MOST RECENT ASSESSMENTS AND RISK MAPS PRODUCED BY THE NATIONAL CENTER FOR MEDICAL INTELLIGENCE (NCMI) AT HTTPS://WWW.NCMI.DETRICK.ARMY.MIL/ (UNCLASSIFIED) OR HTTPS://WWW.NCMI.DIA.SMIL.MIL (CLASSIFIED).

15.L.1.B.1. BASED ON NCMI RISK ASSESSMENTS AND IN CONSULTATION WITH THE THEATER PREVENTIVE MEDICINE CONSULTANT, RECOMMENDATIONS FOR MODIFIED CHEMOPROPHYLAXIS POLICY MAY BE PROVIDED TO COMMANDERS USING REF BB OR SIMILAR RISK ANALYSIS.

15.L.1.B.2. MANEUVER FORCES WITH INTERMITTENT AND UNPREDICTABLE EXPOSURES TO RISK AREAS SHOULD EMPLOY CHEMOPROPHYLAXIS BASED ON THE HIGHEST RISK AREAS. UNITS AND INDIVIDUALS WITH VERY SHORT TERM EXPOSURE (I.E., AIRCREW NOT STATIONED IN THE AOR) SHOULD HAVE RISK AND CHEMOPROPHYLAXIS USE DETERMINED IAW SERVICE POLICY.

15.L.2. MALARIA CHEMOPROPHYLAXIS UTILIZATION.

15.L.2.A. ALL THERAPEUTIC/CHEMOPROPHYLACTIC MEDICATIONS, INCLUDING ANTIMALARIALS AND MCDM WILL BE PRESCRIBED IAW FDA GUIDELINES, REF C, BB, CC, AND DD.

15.L.2.B. DOXYCYCLINE OR ATOVAQUONE/PROGUANIL (MALARONE®) ARE GENERALLY ACCEPTABLE AS A PRIMARY MALARIA CHEMOPROPHYLACTIC AGENT. MEFLOQUINE SHOULD BE CONSIDERED THE DRUG OF LAST RESORT FOR PERSONNEL WITH CONTRAINDICATIONS TO DOXYCYCLINE OR MALARONE®, SHOULD BE USED WITH CAUTION IN PERSONS WITH A HISTORY OF TBI OR PTSD, AND IS CONTRAINDICATED IN PERSONNEL WITH PSYCHIATRIC DIAGNOSES. EACH MEFLOQUINE PRESCRIPTION WILL BE ISSUED WITH A WALLET CARD AND CURRENT FDA SAFETY INFORMATION INDICATING THE POSSIBILITY THAT THE NEUROLOGIC SIDE EFFECTS MAY PERSIST OR BECOME PERMANENT IAW REF DD. OTHER FDA APPROVED AGENTS MAY BE USED TO MEET SPECIFIC SITUATIONAL REQUIREMENTS.

15.L.2.C. PERSONNEL SHOULD DEPLOY WITH EITHER THEIR ENTIRE PRIMARY PROPHYLAXIS COURSE IN HAND (EXCLUDING TERMINAL PRIMAQUINE) OR WITH ENOUGH MEDICATION TO COVER HALF OF THE DEPLOYMENT WITH PLANS TO RECEIVE THE REMAINDER OF THEIR MEDICATION IN THEATER BASED ON UNIT PREFERENCE. TERMINAL PROPHYLAXIS (PRIMAQUINE) SHOULD BE DISTRIBUTED UPON REDEPLOYMENT AND ONLY AFTER VERIFYING G6PD STATUS (SEE 15.G.3.). A COMPLETE COURSE OF PRIMARY PROPHYLAXIS BEGINS 2 DAYS PRIOR TO ENTERING THE RISK AREA FOR DOXYCYCLINE AND MALARONE®(2 WEEKS FOR MEFLOQUINE)AND COMPLETES AFTER 4 WEEKS OF DOXYCYCLINE OR MEFLOQUINE AFTER LEAVING THE AT RISK AREA, OR (1 WEEK OF MALARONE®). TERMINAL PROPHYLAXIS IS REQUIRED AND CONSISTS OF TAKING PRIMAQUINE FOR 2 WEEKS AFTER LEAVING THE RISK AREA. INDIVIDUALS WHO ARE NOTED TO BE G6PD-DEFICIENT, IAW PARAGRAPH 15.G.3., WILL NOT BE PRESCRIBED PRIMAQUINE.

15.L.2.D. MISSING ONE DOSE OF MEDICATION OR NOT USING THE DOD INSECT REPELLENT SYSTEM WILL PLACE PERSONNEL AT INCREASED RISK FOR MALARIA.

15.L.2.E. COMMANDERS AND SUPERVISORS AT ALL LEVELS WILL ENSURE THAT ALL INDIVIDUALS FOR WHOM THEY ARE RESPONSIBLE HAVE TERMINAL PROPHYLAXIS ISSUED TO THEM IMMEDIATELY UPON REDEPLOYMENT FROM THE AT RISK MALARIA AREA(S).

15.L.3. PERSONAL PROTECTIVE MEASURES. A SIGNIFICANT RISK OF DISEASE CAUSED BY INSECTS AND TICKS EXISTS YEAR-ROUND IN THE AOR. THE THREAT OF DISEASE WILL BE MINIMIZED BY USING THE DOD INSECT REPELLANT SYSTEM AND BED NETS; HTTP://WWW.AFPMB.ORG. SEE REF EE.

15.L.3.A. PERMETHRIN TREATMENT OF UNIFORMS. UNIFORMS ARE AVAILABLE FOR ISSUE WHICH ARE FACTORY-TREATED WITH PERMETHRIN. THE UNIFORM LABEL INDICATES WHETHER IT IS FACTORY TREATED. UNIFORMS WHICH ARE NOT FACTORY TREATED SHOULD BE TREATED WITH THE INDIVIDUAL DYNAMIC ABSORPTION (IDA) KIT (NSN: 6840-01-345-0237) OR 2 GALLON SPRAYER PERMETHRIN TREATMENT. BOTH ARE EFFECTIVE FOR APPROXIMATELY 50 WASHINGS. A MATRIX OF WHICH UNIFORMS MAY BE EFFECTIVELY TREATED IS AVAILABLE ON THE AFPMB WEBSITE AT HTTP://WWW.AFPMB.ORG .

15.L.3.B. APPLY DEET CREAM (NSN: 6840-01-284-3982) TO EXPOSED SKIN. ONE APPLICATION LASTS 6-12 HOURS; MORE FREQUENT APPLICATION IS REQUIRED IF HEAVY SWEATING AND/OR IMMERSION IN WATER. A SECOND OPTION IS 'SUNSECT CREAM' (20% DEET/SPF 15), NSN: 6840-01-288-2188.

15.L.3.C. WEAR TREATED UNIFORM PROPERLY TO MINIMIZE EXPOSED SKIN (SLEEVES DOWN AND PANTS TUCKED INTO BOOTS).

15.L.3.D. USE PERMETHRIN TREATED BEDNETS PROPERLY IN AT RISK AREAS TO MINIMIZE EXPOSURE DURING REST/SLEEP PERIODS. PERMETHRIN TREATED POP UP BEDNETS ARE AVAILABLE: NSN 3740-01-516-4415

15.L.4. HEALTH SURVEILLANCE. SEE REF C AND FF.

15.L.4.A. JOINT MEDICAL WORKSTATION (JMEWS) THROUGH MSAT AT HTTPS://MSAT.FHP.SMIL.MIL/PORTAL

15.L.4.A.1. DEPLOYED UNITS WILL USE JMEWS AS THE PRIMARY DATA ENTRY POINT FOR DISEASE AND INJURY (DI) REPORTING. UNITS WILL ENSURE ALL SUBORDINATE UNITS COMPLETE JOINING AND DEPARTING REPORTS AS REQUIRED WITHIN JMEWS. SHIPBOARD UNITS SHOULD UTILIZE SAMS OR TMIP-M FOR DI REPORTING AND FIXED MTF'S SHOULD UTILIZE AHLTA.
15.L.4.A.2. UNITS WILL COORDINATE JMEWS TRAINING PRIOR TO DEPLOYMENT FOR APPROPRIATE PERSONNEL TO THE MAXIMUM EXTENT POSSIBLE. CURRENTLY, THE ARMY USES MC4 TRAINERS TO TRAIN JMEWS, THE AIR FORCE USES THEATER MEDICAL INFORMATION PROGRAM (TMIP-AF). INFORMATION MANAGERS, OTHER SERVICES DO NOT HAVE DIRECTED TRAINERS AT THIS TIME.
15.L.4.B. DI SURVEILLANCE, SEE REF GG.
15.L.4.B.1. THE LIST OF DI REPORTING CATEGORIES, THEIR DEFINITIONS, AND THE ESSENTIAL ELEMENTS OF THE STANDARD DI REPORT CAN BE FOUND IN ENCLOSURE C OF REF FF.
15.L.4.B.2. COMPONENT AND JTF SURGEONS ARE RESPONSIBLE FOR ENSURING UNITS WITHIN THEIR AOR ARE COLLECTING THE PRESCRIBED DI DATA AND REPORTING THAT DATA THROUGH THE JMEWS OR OTHER STANDARDIZED REPORTING PROCESSES ON A WEEKLY BASIS.
15.L.4.B.3. MEDICAL PERSONNEL AT ALL LEVELS WILL ANALYZE THE DI DATA FROM THEIR UNIT AND THE UNITS SUBORDINATE TO THEM AND MAKE CHANGES AND RECOMMENDATIONS AS REQUIRED TO REDUCE DI AND MITIGATE THE EFFECTS OF DI UPON OPERATIONAL READINESS.
15.L.4.C. OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE (OEHSA)
15.L.4.C.1. AUTHORITY. AN OEHSA IS A JOINT APPROVED PRODUCT USED TO PROVIDE A COMPREHENSIVE ASSESSMENT OF BOTH OCCUPATIONAL AND ENVIRONMENTAL HEALTH HAZARDS ASSOCIATED WITH DEPLOYMENT LOCATIONS AND ACTIVITIES AND MISSIONS THAT OCCUR THERE ESTABLISHED BY REF D AND FF.
15.L.4.C.2 TIMEFRAME. AN OEHSA IS INITIATED WITHIN 30 DAYS OF DATE OF ESTABLISHMENT AND COMPLETED WITHIN THREE MONTHS FOR ALL PERMANENT AND SEMI-PERMANENT BASE CAMPS. OEHSA ARE CONDUCTED TO VALIDATE ACTUAL OR POTENTIAL HEALTH THREATS, EVALUATE EXPOSURE PATHWAYS, AND DETERMINE COURSES OF ACTION AND COUNTERMEASURES TO CONTROL OR REDUCE THE HEALTH THREATS AND PROTECT THE HEALTH OF DEPLOYED PERSONNEL.
15.L.4.C.3. CLASSIFICATION/PUBLICATION/ACCESS. OEHSA WILL BE SENT BY THE COMPLETING UNIT THROUGH THE DESIGNATED SERVICE COMPONENT OR JTF PM/FHP OFFICER FOR REVIEW AND SUBMITTED DIRECTLY TO THE DEFENSE OCCUPATIONAL AND ENVIRONMENTAL READINESS SYSTEM (DOEHRS) AT HTTPS://DOEHRS-IH.CSD.DISA.MIL/. SEE APPENDIX J TO REFERENCE EE FOR DOEHRS REQUIREMENTS. IF THE SUBMITTER DOES NOT HAVE ACCESS TO DOEHRS SUBMIT THE OEHSA TO THE MILITARY EXPOSURE SURVEILLANCE LIBRARY (MESL) HTTPS://MESL.APGEA.ARMY.MIL/MESL/. IF THE MESL IS NOT AVAILABLE, EMAIL THE DOCUMENT TO OEHS.DATA@US.ARMY.MIL. CLASSIFIED EXPOSURE DATA SHOULD BE SUBMITTED DIRECTLY TO MESL-S HTTPS://MESL.CSD.DISA.SMIL.MIL. IF ACCESS TO THE MESL-S IS NOT AVAILABLE, EMAIL THE DOCUMENT TO OEHS@USACHPPM.ARMY.SMIL.MIL.
15.L.4.C.4. RESPONSIBILITIES. SERVICE COMPONENTS AND JTFS ARE RESPONSIBLE FOR APPROVING OEHSA COMPLETION AND WILL SUBMIT A MONTHLY REPORT IAW PROCEDURES OUTLINED IN REFERENCE GG.
15.L.4.D. PERIODIC OCCUPATIONAL AND ENVIRONMENTAL MONITORING SUMMARY (POEMS).
15.L.4.D.1. AUTHORITY. POEMS IS A JOINT APPROVED PRODUCT USED TO ADDRESS ENVIRONMENTAL EXPOSURE DOCUMENTATION REQUIREMENTS ESTABLISHED BY REF D AND FF.

15.L.4.D.2. TIMEFRAME. POEMS WILL BE CREATED AND VALIDATED FOR EVERY MAJOR DEPLOYMENT SITE AS SOON AS SUFFICIENT DATA IS AVAILABLE. IN GENERAL, POEMS ARE A SUMMARY OF INFORMATION REFLECTING A YEAR OR MORE OF ENVIRONMENTAL AND OCCUPATIONAL HEALTH DATA TO ENSURE ADEQUATE COLLECTION OF EXPOSURE INFORMATION.

15.L.4.D.3. CLASSIFICATION/PUBLICATION/ACCESS. POEMS WILL BE UNCLASSIFIED BUT POSTED ON THE PASSWORD PROTECTED DEPLOYMENT OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE DATA PORTAL AT HTTPS://MESL.APGEA.ARMY.MIL/MESL/ WHERE JOINT OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE DATA AND REPORTS ARE STORED. THE POEMS TEMPLATE CAN BE FOUND AT HTTP://PHC.AMEDD.ARMY.MIL.

15.L.4.D.4. RESPONSIBILITIES. SERVICE COMPONENTS AND JTFS ARE RESPONSIBLE FOR ENSURING POEMS ARE COMPLETED FOR SITES IN THEIR RESPECTIVE AOR. THEY SHOULD DEVELOP SITE PRIORITIZATION LISTS AND ENLIST THE SUPPORT OF SERVICE PUBLIC HEALTH ORGANIZATIONS (E.G., U.S. ARMY PUBLIC HEALTH CENTER (USAPHC)) TO DRAFT THE CONTENT OF A SITE POEMS. THE USAPHC OVERSEES THE DATA ARCHIVAL WEBSITE FOR PUBLICATION OF FINAL POEMS AND ASSOCIATED DOCUMENTS; HOWEVER, APPROVAL OF "FINAL" POEMS MUST COME FROM THE SERVICE COMPONENT/JTF FHP OFFICER WITH INPUT FROM PREVENTIVE MEDICINE RESOURCES IN DIRECT OR GENERAL AREA SUPPORT.

15.L.5. REPORTABLE MEDICAL EVENT (RME) SURVEILLANCE. SEE REF O, GG.

15.L.5.A. THE LIST OF DISEASES AND CONDITIONS THAT MUST BE REPORTED CAN BE FOUND IN THE TRI-SERVICE REPORTABLE EVENTS GUIDELINES AND CASE DEFINITIONS AT HTTP://WWW.AFHSC.MIL OR REF HH.

15.L.5.B. COMPONENT AND JTF SURGEONS ARE RESPONSIBLE FOR ENSURING UNITS WITHIN THEIR AO ARE COLLECTING THE APPROPRIATE RME DATA AND REPORTING THAT DATA THROUGH THEIR SERVICE SPECIFIC REPORTING MECHANISMS.

15.L.5.B.1. IT IS ONLY REQUIRED TO COPY CCSG FOR THE FOLLOWING RMES AT CCSG-PMO@CENTCOM.SMIL.MIL OR CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL: ANTHRAX; BOTULISM; CBRN AND TOXIC INDUSTRIAL CHEMICAL/MATERIAL (TIC/TIM) EXPOSURE; SEVERE COLD WEATHER/HEAT INJURIES; DENGUE FEVER; HANTAVIRUS DISEASE; HEMORRHAGIC FEVER; HEPATITIS B OR C, ACUTE; HIV; MALARIA; MEASLES; MENINGOCOCCAL DISEASE; MIDDLE EASTERN RESPIRATORY SYNDROME CORONAVIRUS (MERS-COV); NOROVIRUS; OUTBREAK OR DISEASE CLUSTER; PLAGUE; PNEUMONIA, EOSINOPHILIC; Q- FEVER; RABIES, HUMAN; SEVERE ACUTE RESPIRATORY INFECTIONS (SARI); STREPTOCOCCUS, INVASIVE GROUP A; TETANUS; TUBERCULOSIS, ACTIVE; TULAREMIA; TYPHOID FEVER; VARICELLA

15.L.5.C. RME REPORTING IS TO OCCUR AS SOON AS REASONABLY POSSIBLE AFTER THE EVENT HAS OCCURRED. EVENTS WITH BIOTERRORISM POTENTIAL OR RAPID OUTBREAK POTENTIAL ARE CONSIDERED URGENT RME AND IMMEDIATE REPORTING IS REQUIRED (WITHIN FOUR HOURS).

15.L.6. HEALTH RISK COMMUNICATION. SEE REF C.

15.L.6.A. DURING ALL PHASES OF DEPLOYMENT, PROVIDE HEALTH INFORMATION TO EDUCATE, MAINTAIN FIT FORCES, AND CHANGE HEALTH RELATED BEHAVIORS FOR THE PREVENTION OF DISEASE AND INJURY DUE TO RISKY PRACTICES AND UNPROTECTED EXPOSURES.

15.L.6.B. CONTINUAL HEALTH RISK ASSESSMENTS ARE ESSENTIAL ELEMENTS OF THE HEALTH RISK COMMUNICATION PROCESS DURING THE DEPLOYMENT PHASE. MEDICAL PERSONNEL AT ALL LEVELS WILL PROVIDE WRITTEN AND ORAL RISK COMMUNICATION PRODUCTS TO

COMMANDERS AND DEPLOYED PERSONNEL FOR MEDICAL THREATS, COUNTERMEASURES TO THOSE THREATS, AND THE NEED FOR ANY MEDICAL FOLLOW-UP.

15.L.6.C. DI, RME, AND OCCUPATIONAL AND ENVIRONMENTAL HEALTH (OEH) RISK ASSESSMENTS WITH RECOMMENDED COUNTERMEASURES WILL BE PROVIDED TO COMMANDERS AND DEPLOYED PERSONNEL ON A REGULAR BASIS AS WELL AS A SITUATIONAL BASIS WHEN A SIGNIFICANT CHANGE IN ANY ASSESSMENT OCCURS.

15.L.7. HEALTH CARE MANAGEMENT.

15.L.7.A. JOINT TRAUMA SYSTEM (JTS) CLINICAL PRACTICE GUIDELINES (CPGS) MAY BE OBTAINED AT THE UNITED STATES ARMY INSTITUTE OF SURGICAL RESEARCH (USAISR) WEBSITE AT HTTP://WWW.USAISR.AMEDD.ARMY.MIL/CPGS.HTML.

15.L.7.B. DOCUMENTATION OF ALL MEDICAL AND DENTAL CARE RECEIVED WHILE DEPLOYED WILL BE IAW CENTCOM MEDICAL INFORMATION MANAGEMENT GUIDELINES. SEE REF II.

15.L.7.C. IT IS A COMMANDER'S RESPONSIBILITY TO ENSURE THAT ALL PERSONNEL POTENTIALLY AFFECTED BY A BLAST OR OTHER POTENTIALLY CONCUSSIVE EVENT (PCE) ARE EVALUATED FOR TRAUMATIC BRAIN INJURY (TBI) BY A MEDICAL PROVIDER AND DOCUMENTATION IS COMPLETED IAW REF JJ.

15.L.8. UNIT MASCOTS AND PETS.

15.L.8.A. PER CENTCOM GENERAL ORDER 1.C, DEPLOYED PERSONNEL WILL AVOID CONTACT WITH LOCAL ANIMALS (E.G., LIVESTOCK, CATS, DOGS, BIRDS, REPTILES, ARACHNIDS, AND INSECTS) IN THE DEPLOYED SETTING AND WILL NOT FEED, ADOPT, OR INTERACT WITH THEM IN ANY WAY.

15.L.8.B. ANY CONTACT WITH LOCAL ANIMALS, WHETHER INITIATED OR NOT, THAT RESULTS IN A BITE, SCRATCH OR POTENTIAL EXPOSURE TO THE ANIMAL'S BODILY FLUIDS (SALIVA, VENOM, ETC.) WILL BE IMMEDIATELY REPORTED TO THE CHAIN OF COMMAND AND MEDICAL PERSONNEL FOR EVALUATION AND FOLLOW-UP.

15.L.9. FOOD AND WATER SOURCES.

15.L.9.A. ALL WATER (INCLUDING ICE) IS CONSIDERED NON-POTABLE UNTIL TESTED AND APPROVED BY APPROPRIATE MEDICAL PERSONNEL (ARMY OR NAVY PREVENTIVE MEDICINE, AIR FORCE BIOENVIRONMENTAL ENGINEERING, INDEPENDENT DUTY MEDICAL TECHNICIAN/CORPSMAN). COMMERCIAL SOURCES OF DRINKING WATER MUST ALSO BE APPROVED BY THE U.S. ARMY PUBLIC HEALTH CENTER.

15.L.9.B. NO FOOD SOURCES WILL BE UTILIZED UNLESS INSPECTED AND APPROVED BY U.S. ARMY PUBLIC HEALTH CENTER (I.E. VETERINARY PERSONNEL).

15.L.9.C. COMMANDERS WILL ENSURE THE NECESSARY SECURITY TO PROTECT WATER AND FOOD SUPPLIES AGAINST TAMPERING BASED ON RECOMMENDATIONS PROVIDED IN FOOD/WATER VULNERABILITY ASSESSMENTS. MEDICAL PERSONNEL WILL PROVIDE CONTINUAL VERIFICATION OF QUALITY AND PERIODIC INSPECTION OF STORAGE AND PREPARATION FACILITIES.

15.L.10. ENVIRONMENTAL EXPOSURES OF CONCERN.

15.L.10.A. COLD INJURY RISK WILL DEPEND ON THE SPECIFIC REGION. HYPOTHERMIA, A LIFE-THREATENING CONDITION, MOSTLY OCCURS UP TO 55 DEGREES FAHRENHEIT AIR TEMPERATURE. RISK OF COLD INJURY INCREASES FOR PERSONS WHO ARE IN POOR PHYSICAL CONDITION, DEHYDRATED, WET, OR AT INCREASED ALTITUDE. COUNTERMEASURES INCLUDE PROPER WEAR OF CLOTHING AND COVER. EXPOSED SKIN IS MORE LIKELY TO DEVELOP FROSTBITE. ENSURE CLOTHING IS CLEAN, LOOSE, LAYERED, AND DRY. COVER THE HEAD TO CONSERVE HEAT.

15.L.10.B. HEAT STRESS/ SOLAR INJURIES/ILLNESS. HEAT INJURIES MAY BE THE GREATEST OVERALL THREAT TO MILITARY PERSONNEL DEPLOYED TO WARM CLIMATES. ACCLIMATIZATION TO INCREASED TEMPERATURE AND HUMIDITY MAY TAKE 10 TO 14 DAYS.

HEAT INJURIES CAN INCLUDE DEHYDRATION, SUNBURN, HEAT SYNCOPE, HEAT EXHAUSTION AND HEAT STROKE. ENSURE PROPER WORK-REST CYCLES, ADEQUATE HYDRATION, AND COMMAND EMPHASIS ON HEAT INJURY PREVENTION. ENSURE AVAILABILITY AND USE OF INDIVIDUAL PROTECTION SUPPLIES AND EQUIPMENT SUCH AS SUNSCREEN, LIP BALM, SUN GOGGLES/GLASSES, AND POTABLE WATER.

15.L.10.C. ALTITUDE. OPERATIONS AT HIGH ALTITUDES (OVER 9888 FT) CAN CAUSE A SPECTRUM OF ILLNESSES, INCLUDING ACUTE MOUNTAIN SICKNESS; HIGH ALTITUDE PULMONARY EDEMA, HIGH ALTITUDE CEREBRAL EDEMA, OR RED BLOOD CELL SICKLING IN SERVICE MEMBERS WITH SICKLE CELL TRAIT. ASCEND GRADUALLY, IF POSSIBLE. TRY NOT TO GO DIRECTLY FROM LOW ALTITUDE TO >9,888 FT (3,013 M) IN ONE DAY. A HEALTH CARE PROVIDER MAY PRESCRIBE ACETAZOLAMIDE (DIAMOX) OR DEXAMETHASONE (DECADRON) TO SPEED ACCLIMATIZATION IF ABRUPT ASCENT IS UNAVOIDABLE. TREAT AN ALTITUDE HEADACHE WITH SIMPLE ANALGESICS; MORE SERIOUS COMPLICATIONS REQUIRE OXYGEN AND IMMEDIATE DESCENT.

15.L.10.D. GOOD FIELD SANITATION PRACTICES ARE ESSENTIAL TO MAINTAIN FORCE HEALTH. THEY INCLUDE: FREQUENT HANDWASHING, PROPER DENTAL CARE, CLEAN AND DRY CLOTHING (ESPECIALLY SOCKS, UNDERWEAR, AND BOOTS), BATHING AND DENTAL CARE WITH WATER FROM A POTABLE SOURCE. CHANGE SOCKS FREQUENTLY, FOOT POWDER HELPS PREVENT FUNGAL INFECTIONS.

15.M. ALL OTHER INSTRUCTIONS AND GUIDANCE SPECIFIED IN INITIAL POLICY MESSAGE REMAIN IN EFFECT. MOD TWELVE IS NOW INVALID.

15.N. THE USCENTCOM POC FOR PREVENTIVE MEDICINE/FORCE HEALTH PROTECTION IS CCSG, DSN 312-529-0345; COMM: 813-529-0345; SIPR: CCSG-PMO@CENTCOM.SMIL.MIL OR KEVIN.CRON@CENTCOM.SMIL.MIL; NIPR: CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL OR KEVIN.M.CRON.MIL@MAIL.MIL//

PPG-TAB A: AMPLIFICATION OF THE MINIMAL STANDARDS OF FITNESS FOR DEPLOYMENT TO THE CENTCOM AOR; TO ACCOMPANY MOD TWELVE TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY

1. General. This PPG-TAB A accompanies MOD TWELVE, Section 15.C. and provides amplification of the minimal standards of fitness for deployment to the CENTCOM area of responsibility (AOR), including a list of medical conditions that may be sufficient to deny medical clearance for or to disapprove deployment of a service member, civilian employee, volunteer, or contractor's employee. The list of deployment-limiting conditions is not comprehensive; there are many other conditions that may result in denial of medical clearance for deployment. Possession of one or more of the conditions listed in this tab does not automatically imply that the individual may not deploy. Conversely, in addition to any specified disqualifying condition, one must also take into account the totality of one's medical conditions and the medical capabilities present at that individual's deployed location. This imposes the requirement to obtain a knowledgeable physician's opinion as to the deployability status of the individual and a valid deployment medical waiver from the appropriate waiver authority for the potentially medically disqualifying condition. "Medical conditions" as used here also include those health conditions usually referred to as dental, psychological and/or emotional.

A. Uniformed Service Members will be evaluated for fitness according to service regulations and policies, in addition to the guidance in the parent PPG Modification (MOD). See MOD TWELVE REF E, F, G, H, O, Q and HH.

B. DoD civilian personnel with apparently disqualifying medical conditions could still possibly deploy based upon an individualized medical assessment, waiver submission and disposition by the appropriate CENTCOM waiver authority (which shall be consistent with subparagraph 4.g.(3)(c) of DoDD 1404.10 and The Rehabilitation Act of 1973, as amended).

C. DoD Contract personnel will be evaluated for fitness according to DoDI 3020.41 (REF J).

D. Waivers for Uniformed Service Members, DoD civilian personnel and DoD Contract personnel will be considered only if all the following general conditions are met:

1. The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.

2. The condition is stable and reasonably anticipated by the pre-deployment medical evaluator not to worsen during the deployment in light of physical, physiological, psychological, and nutritional effects of the duties and location.

3. The condition does not require frequent clinical visits (more than quarterly) or ancillary tests (more than twice/year), does not necessitate significant limitations of physical activity or constitutes increased risk of illness, injury, or infection.

4. There is no need for routine evacuation out of theater for continuing diagnostics or their evaluations. (All such evaluations must be accomplished before deployment.).

5. Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the Military Health System or equivalent. Medication must have no special handling, storage, or other requirements

(e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g. heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration.

6. It is determined, based upon an individualized assessment, that the member can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the member's medical condition must not pose a significant risk of substantial harm to the member or others taking into account the condition of the relevant deployed environment, with particular consideration of areas of armed conflict in the AOR. See REF Q.

7. The medical condition does not prevent the wear of personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical/biological protective garments.

8. The medical condition does not prohibit required theater immunizations (other than smallpox & anthrax per current guidance) or medications (such as antimalarials, chemical and biological antidotes, and other chemoprophylactic antibiotics).

9. Any unresolved acute illness or injury should not impair one's duty performance during the duration of the deployment.

2. The provider evaluating personnel for deployment must bear in mind that in addition to the individual's duties, the environmental conditions that may impact health include extremes of temperature, physiologic demand (water, mineral, salt, and heat management), and poor air quality (especially particulates), while the operating conditions impose extremes of diet (to include fat, salt, and caloric levels), sleep deprivation, emotional stress, and sleep disturbance. If maintaining an individual's health requires avoidance of these extremes or conditions, she/he should not deploy.

3. The rules and facts listed in paragraph 2 should assist the evaluating medical authority to make qualified judgments as to whether an individual with an existing condition is suitable for deployment. Any condition that markedly impairs an individual's daily function is grounds for disapproval. Evaluation of functional capacity to determine fitness in conditions of physiologic demand is encouraged to make a decision. This includes such things as a complete cardiac evaluation to include stress imaging, when there is coronary artery disease or significant risk thereof or an official functional capacity exam (FCE) as determined by the initial evaluating provider. The evaluating provider should pay special attention to hematologic, cardiovascular, pulmonary, orthopedic, neurological, endocrine, dermatological, psychological, visual, and auditory conditions which may present a hazard to the individual or others and/or preclude performing functional requirements in the deployed setting. Also, the type and amount of medications being taken, their suitability, and availability in the theater environment must be considered as potential limitations. Pre-deployment processing centers may vary in medical examination/screening procedures; individuals should contact their respective mobilization site for availability of a processing checklist.

4. The guidance in this document should not be construed as authorizing use of defense health program or military health system resources for such evaluations unless previously authorized. Generally, Defense Health Agency and Military Health System resources are not authorized for the purpose of pre-deployment or travel medicine evaluations for contractor employees IAW REF J. Local command, legal, contracting and resource management authorities should be consulted for questions on this matter.

5. Shipboard operations that are not anticipated to involve operations ashore are exempt from the deployment-limiting medical conditions listed below and will follow Service specific guidance.

6. The general guidance from MOD TWELVE section 15.C applies to:

A. All personnel (uniformed service members, government civilian employees, volunteers, and DoD contractor employees) deploying to theater must be medically, dentally and psychologically fit for deployment and possess a current Periodic Health Assessment (PHA) or physical. Fitness specifically includes the ability to accomplish tasks and duties unique to a particular operation and the ability to tolerate environmental and operational conditions of the deployed location.

B. The existence of a chronic medical condition may not necessarily require a waiver to deploy. Personnel with existing conditions, **other than those outlined in this document**, may deploy if either:

1. An approved medical waiver, IAW Section 15.C.3, is documented in the medical record.

OR

2. The conditions in Para. 1.D.1-1.D.9 are met and for most conditions, 90 days is a reasonable timeframe to determine stability, and assess need for further care, subject to the examining provider's judgment. The exception to this is noted in paragraph 7.G. Psychiatric Conditions.

7. Documented medical conditions precluding medical clearance. A list of all possible diagnoses and their severity that may cause an individual to be non-deployable would be too expansive. *Rather than relying solely on a specific list of medical conditions, the medical evaluator must carefully consider whether the climate, altitude, nature of available food and housing, availability of medical, behavioral health, dental, surgical, and laboratory services, or whether other environmental and operational factors may be hazardous to the deploying person's health because of a known physical or psychological condition.* The following list of conditions should not be considered exhaustive. Other conditions may render an individual medically non-deployable (see paragraph 6). Medical clearance to deploy with any of the following documented medical conditions may be granted, except where otherwise noted, IAW MOD TWELVE Section 15.C. If an individual is found deployed with a *pre-existing* non-deployable condition and without a waiver for that condition, a waiver request to remain deployed should be submitted to the respective Component Surgeon. If the waiver request is denied, the individual will be redeployed out of the CENTCOM AOR. **Individuals with the following conditions will not deploy without an approved waiver:**

A. Specific Medical Conditions / Restrictions:

1. Asthma or other respiratory conditions that have a Forced Expiratory Volume-1 $\leq$ 50% of predicted despite appropriate therapy, that has required hospitalization in the past 12 months, or that requires daily systemic (not inhaled) steroids. Respiratory conditions that have been well controlled for 6 months and are evaluated to pose no risk of deterioration in the deployed environment may be considered for waiver.
2. Seizure disorder, either within the last year or currently on anticonvulsant medication for prior seizure disorder/activity. Persons on a stable anticonvulsant regimen, who have been seizure-free for one year, may be considered for waiver.
3. Diabetes mellitus, type 1 or 2, on pharmacotherapy or with $HgA_1C > 7.0$.

a. Type 1 diabetes or insulin-requiring type 2 diabetes..

b. Type 2 diabetes, on oral agents only, with no change in medication within the last 90 days and HgA1C ≤ 7.0 does not require a waiver if the calculated 10-year Framingham coronary heart disease risk percentage is less than 15% based on the NCEP ATP III guidelines. If the calculated 10-year risk is 15% or greater, further evaluation is required prior to waiver submission. See B.8. for more detailed instructions.

c. Newly diagnosed diabetics will require 90 days of stability, either on oral medications or with lifestyle changes, before a waiver will be considered. They should also have documentation of a complete initial diabetic evaluation (eye exam, foot exam, nutrition counseling, etc.).

4. History of heat stroke. No multiple episodes, no persistent sequelae or organ damage and no episode within the last 24 months may be considered for waiver.

5. Meniere's disease or other vertiginous/motion sickness disorder, unless well controlled on medications available in theater.

6. Recurrent syncope for any reason. Waiver request should include the etiology and diagnosis of the condition.

7. Any musculoskeletal condition that significantly impairs performance of duties in a deployed environment. If there are concerns, an official functional capacity exam (FCE) should be performed and results included with the waiver request.

8. Renalithiasis, recurrent or currently symptomatic.

9. Pregnancy.

10. Obstructive sleep apnea (OSA). The OSA is diagnosed with an attended, in-laboratory polysomnography (PSG) with a minimum of 2 hours of total sleep time, that yields an apnea-hypopnea index (AHI), and/or respiratory disturbance index (RDI), of greater than 5 / hour. Unattended, home PSG is not acceptable for deployment purposes. For individuals previously diagnosed with OSA, updated or repeat PSG is not required unless clinically indicated (i.e. significant change in body habitus, corrective surgery or return of OSA symptoms). Individuals treated with an oral appliance require PSG documentation that OSA is controlled with its use. Individuals who are treated with automatic positive airway pressure (APAP), continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BPAP) are acceptable as long as the condition being treated is OSA and not a more complex respiratory disorder. Complex OSA, central sleep apnea or OSA that requires advanced modes of ventilation such as adaptive servo-ventilation (ASV) or average volume assured pressure support (AVAPS) is generally non-deployable. Individuals using PAP therapy should deploy with a machine that has rechargeable battery back-up and sufficient supplies (air filters, tubing and interfaces/masks) for the duration of the deployment. Individuals deploying with PAP therapy to a location where the sleep environment has unfiltered air will typically not be granted waivers if a waiver is otherwise required per the guidance below. The following guidelines are designed to ensure that individuals with OSA are adequately treated and that their condition is not of the severity that would pose a safety risk should they be required to go without their PAP therapy for a significant length of time.

a. Symptomatic OSA (i.e. excessive daytime sleepiness) of any severity, with or without any treatment.

b. Asymptomatic mild OSA (diagnostic AHI and RDI < 15/hr): Deployable with or without treatment (PAP or otherwise). **No waiver required.**

c. Moderate OSA (diagnostic AHI or RDI ≥15/hr and < 30/hr): **No waiver required** to deploy if successfully treated (CPAP or otherwise), except to Afghanistan, Iraq or Yemen.
d. Severe OSA (AHI or RDI ≥ 30/hr): Once successfully treated (PAP or otherwise), requires a waiver for deployment to any location in the AOR.
e. For moderate and severe OSA, adherence to positive airway pressure (PAP) therapy must be documented prior to deployment. Adherence is defined as PAP machine data download (i.e. compliance report) that reveals the machine is being used for at least 4 hours per night for greater than 70% of nights over the previous 30 day period.

11. History of clinically diagnosed traumatic brain injury (mTBI/TBI) of any severity, including mild. Such history does not necessitate a waiver request, but does require pre-deployment evaluation, which may include both neurological and psychological components. This is in accordance with DoDI 6490.11, Enclosure 3, paragraph 4, policy guidance for management of mild TBI. This document can be found at http://www.usaisr.amedd.army.mil/clinical_practice_guidelines.html. Individuals who have a history of a single mild Traumatic Brain Injury may deploy once released by a medical provider after 24 hours symptom free. Individuals who have sustained a second mTBI within a 12 month period, may deploy after seven days symptom free and release by a medical provider. Individuals who have had three clinically diagnosed TBIs (of any severity, including mild) since their last full neurological and psychological DoDI 6490.11 defined evaluation are required to have such an evaluation completed prior to deployability determination.
12. BMI > 35 with serious comorbidities such as; diabetes, cardiovascular disease, hypertension, sleep apnea, obesity-related cardiomyopathy, severe joint disease, etc.
13. Any medical conditions (except OSA-see 10 above) that require certain durable medical equipment or appliances (e.g., nebulizers, catheters, spinal cord stimulators) or that requires periodic evaluation/treatment by medical specialists not readily available in theater.

B. Cardiovascular Conditions:

1. Symptomatic coronary artery disease. Also, see B.8.
2. Myocardial infarction within one year of deployment. Also, see B.8.
3. Coronary artery bypass graft, coronary artery angioplasty, carotid endarterectomy, other arterial stenting, or aneurysm repair within one year of deployment. Also, see B.8.
4. Cardiac dysrhythmias or arrhythmias, either symptomatic or requiring medication, electro-physiologic control, or automatic implantable cardiac defibrillator or other implantable cardiac devices.
5. Hypertension that is controlled with a medication or lifestyle regimen that has been stable for 90 days and requires no changes does not require a waiver. Single episode hypertension found on predeployment physical should be accompanied by serial blood pressure checks (3 day BP checks) to ensure hypertension is not persistent.
6. Heart failure or history of heart failure.
7. Morbid obesity (BMI ≥ 40 or weight greater than 300 pounds) in accordance with National Heart Lung and Blood Institute guidelines without any significant comorbidities. Military personnel in compliance with service body fat guidelines do not require a waiver.

Civilians and contractors should submit a body fat worksheet with the waiver request. A BMI calculator is located at http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm

8. Civilian personnel who are 40 years of age or older must have a Framingham 10-year CHD risk percentage calculated (online calculator is available at http://cvdrisk.nhlbi.nih.gov/calculator.asp). If the individual's calculated 10-year CHD risk is 15% or greater, the individual should be referred for further cardiology work-up and evaluation, to include at one of the following: graded exercise stress test with a myocardial perfusion scintigraphy (SPECT scan) or stress echocardiography as determined by the evaluating cardiologist. Results of the evaluation (physical exam, Framingham results, etc.) and testing, along with the evaluating physician's recommendation regarding suitability for deployment, should be included in a waiver request to deploy.

9. Uncontrolled hyperlipidemia. Lipid screening should be accomplished IAW Service specific guidelines for lipid assessment. All others (e.g. civilians, contractors) ≥35 years old should have a lipid screening profile performed prior to deployment. While hyperlipidemia should be addressed IAW clinical treatment guidelines, hyperlipidemia values that are outside any of the following (Total Cholesterol > 260, LDL > 190, Triglycerides > 500), either treated or untreated, requires a waiver to be submitted.

C. Infectious Disease:

1. Blood-borne diseases (Hepatitis B, Hepatitis C, HTLV) that may be transmitted to others in a deployed environment. Waiver requests for persons testing positive for a blood borne disease should include a full test panel for the disease, including all antigens, antibodies and viral load.

2. Confirmed HIV infection is disqualifying for deployment, IAW References Q and Y, service specific policies, and agreements with host nations.

3. Latent tuberculosis (LTBI), Individuals who are newly diagnosed with LTBI by either TST or IGRA testing will be evaluated for TB disease with at least a symptom screen ,a chest x-ray and they will have documented LTBI evaluation and counseling for consideration of treatment. Those with untreated or incompletely treated LTBI, including those with newly diagnosed LTBI, previously diagnosed LTBI, and those currently under treatment for LTBI will be provided information regarding the risks and benefits of LTBI treatment during deployment (see paragraph 15.G.6.C). Individuals meeting the above criteria **do not require a waiver** for deployment. Active duty TST convertors who have documented completion of public health nursing evaluation for TB disease and counseling for LTBI treatment described above **may deploy without a waiver** as long as all Service specific requirements are met.

4. History of active tuberculosis (TB). Must have documented completion of full treatment course prior to deployment. Those currently on treatment for TB disease may not deploy.

5. A CENTCOM waiver cannot override host or transit nation infectious disease or immunization restrictions. Active duty must comply with status of forces agreements; civilian deployers should contact the nation's embassy for up-to-date information.

D. Eye, Ear, Nose, Throat, Dental Conditions:

1. Vision loss. Best corrected visual acuity must meet job requirements to safely perform duties. Bilateral blindness or visual acuity that is unsafe for the combat environment per the examining provider.

2. Refractive eye surgery. Personnel who have had laser refractive surgery must have a satisfactory period for post-surgical recovery before deployment. There is a large degree of patient variability which prevents establishing a set timeframe for full recovery. The attending ophthalmologist or optometrist will determine when recovery is complete.

a. Personnel are non-deployable while still using ophthalmic steroid drops post-procedure.

b. Photorefractive keratectomy (PRK). Personnel are non-deployable for three months following uncomplicated PRK unless a waiver is granted. Related "surface ablation" procedures such as laser epithelial keratomileusis (LASEK) and epithelial LASIK are to be considered equivalent to PRK. Waiver request should include clearance from treating ophthalmologist or optometrist.

c. Laser assisted in situ keratomileusis (LASIK). Personnel are non-deployable for one month following uncomplicated LASIK unless a waiver is granted. Waiver request should include clearance from treating ophthalmologist or optometrist.

3. Hearing loss. Service members must meet all service-specific requirements. Individuals must have sufficient unaided hearing to perform duties safely and waiver requests should reflect this. Those deploying to combat areas should have an occupationally focused assessment of ability to hear and wake up to emergency alarms unaided and hear instructions in the absence of visual cues such as lip reading. If there is any safety question, Speech Recognition In Noise Test (SPRINT) or equivalent is a recommended adjunct.

4. Tracheostomy or aphonia.

5. Patients without a dental exam within 12 months of deployment, or those who are likely to require evaluation or treatment during the period of deployment for oral conditions that are likely to result in a dental emergency.

a. Individuals being evaluated by a non-DoD civilian dentist should use a DD Form 2813, or equivalent, as proof of dental examination.

b. Individuals with orthodontic equipment require a waiver to deploy. Waiver requests to deploy should include a current evaluation by their treating orthodontic provider and include a statement that wires with neutral force are in place.

E. Cancer:

1. Cancer for which the individual is receiving continuing treatment or requiring frequent subspecialist examination and/or laboratory testing during the anticipated duration of the deployment.

2. Precancerous lesions that have not been treated and/or evaluated and that require treatment/evaluation during the anticipated duration of the deployment.

3. All cancers should be in complete remission for at least a year before a waiver is submitted.

F. Surgery:

1. Any medical condition that requires surgery (e.g., unrepaired hernia) or for which surgery has been performed and the patient requires ongoing treatment, rehabilitation or additional surgery to remove devices (e.g., external fixator placement).

2. Individuals who have had surgery requiring follow up during the deployment period or who have not been cleared/released by their surgeon (excludes minor procedures).
3. Individuals who have had surgery (open or laparoscopic) within 6 weeks of deployment.

G. **Psychiatric Conditions: Waiver required for all conditions listed below (list is not exclusive).** For detailed guidance on deployment-limiting psychiatric conditions or psychotropic medications, refer to Health Affairs Policy Memorandum, "Clinical Practice Guidelines for Deployment-Limiting Mental Disorders and Psychotropic Medications", October 7, 2013 (or most up to date Health Affairs Memorandum).

1. Psychotic and Bipolar Disorders.
2. DSM IV or DSM 5 diagnosed psychiatric disorders with residual symptoms, or medication side effects, which impair social and/or occupational performance.
3. Mental health conditions that pose a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment.
4. Chronic insomnia that requires the use of sedative hypnotics/amnestics, benzodiazepines, and antipsychotics for greater than three months.
5. Psychiatric hospitalization within the last 12 months
6. Suicidal Ideation or Suicide Attempt with the last 12 months
7. Enrollment in substance abuse program (inpatient, service specific substance abuse program or outpatient) within the last 12 months
a. Substance abuse disorders (not in remission), actively enrolled in Service Specific substance abuse programs.
8. Use of antipsychotics or anticonvulsants for stabilization of DSM IV or DSM-5 diagnosis
9. Use of 3 psychotropics (antidepressants, anticonvulsants, antipsychotics and benzodiazepines) for stabilization
10. Psychiatric disorders with fewer than three months of demonstrated stability from the last change in treatment regimen (medication, either new or discontinued, or dose change).
11. Psychiatric disorders newly diagnosed during deployment do not immediately require a waiver or redeployment. Disorders that are deemed treatable, stable, and having no impairment of performance or safety by a credentialed mental health provider do not require a waiver to remain in theater.

H. Medications – although not exhaustive, use of any of the following medications (specific medication or class of medication) is disqualifying for deployment, unless a waiver is granted:

1. Blood modifiers:
a. Therapeutic Anticoagulants: warfarin (Coumadin®), rivaroxaban (Xarelto®).
b. Platelet Aggregation Inhibitors or Reducing Agents: clopidogrel (Plavix®), anagrelide (Agrylin®), Dabigatran (Pradaxa®), Aggrenox®, Ticlid (Ticlopidine®), Prasugrel (Effient®), Pentoxifylline (Trental®), Cilostazol (Pletal®). Note: Aspirin use in theater is to be limited to individuals who have been advised to continue use by their healthcare provider for medical reasons; such use must be documented in the medical record.

c. Hematopoietics: filgrastim (Neupogen®), sargramostim (Leukine®), erythropoietin (Epogen®, Procrit®).

d. Antihemophilics: Factor VIII, Factor IX.

2. Antineoplastics (oncologic or non-oncologic use): e.g., antimetabolites (methotrexate, hydroxyurea, mercaptopurine, etc.), alkylators (cyclophosphamide, melphalan, chlorambucil, etc.), antiestrogens (tamoxifen, etc.), aromatase inhibitors (anastrozole, examestane, etc.), medroxyprogesterone (except use for contraception), interferons, etoposide, bicalutamide, bexarotene, oral tretinoin (Vesanoid®).

3. Immunosuppressants: e.g., chronic systemic steroids.

4. Biologic Response Modifiers (immunomodulators) e.g., abatacept (Orencia®), adalimumab (Humira®), anakinra (Kineret®), etanercept (Enbrel®), infliximab (Remicade®), leflunomide (Arava®), etc.

5. Benzodiazepines: Chronic use or newly prescribed: lorazepam (Ativan), alprazolam (Xanax), diazepam (Valium), clonazepam (Klonopin), etc.

6. CII Stimulants taken for treatment of ADHD/ADD: Ritalin, Concerta, Adderall, Dexedrine, Focalin XR, Vyvanse, etc.

7. Sedative Hypnotics/Amnestics: Taken for greater than three months for treatment of chronic insomnia: zolpidem (Ambien, Ambien CR), eszopiclone (Lunesta),zaleplon (Sonata), estazolam (ProSom), triazolam (Halcion), temazepam (Restoril), flurazepam (Dalmane), etc.

8. Antipsychotics. Including atypical antipsychotic medication.

9. Antimanic (bipolar) agents: e.g., lithium.

10. Anticonvulsants, used for seizure control or psychiatric diagnoses.

a. Anticonvulsants (except those listed below) which are used for *non-psychiatric* diagnoses, such as migraine, chronic pain, neuropathic pain, and post-herpetic neuralgia, are not deployment limiting as long as those conditions meet the criteria set forth in this document and accompanying MOD TWELVE. No waiver required.

b. Valproic acid (Depakote®, Depakote ER®, Depacon®, etc.).

c. Carbamazepine (Tegretol®, Tegretol XR®, etc.).

11. Varenicline (Chantix®). 12. Opioids, opioid combination drugs, or tramadol (Ultram®) for chronic use (greater than 30 days).

12. Insulin and exenatide (Byetta®).

13. Injectable medications of any type.