# EXHIBIT 1

# DoD Instruction 6130.03

# Medical Standards for Appointment, Enlistment, or Induction into the Military Services

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| **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.

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# 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).