EXHIBIT 2

Department of Defense
INSTRUCTION

NUMBER 6485.01
June 7, 2013

USD(P&R)

SUBJECT: Human Immunodeficiency Virus (HIV) in Military Service Members

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)), this instruction reissues DoD Instruction (DoDI) 6485.01 (Reference (b)) to establish policy, assign responsibilities, and prescribe procedures for the identification, surveillance, and management of members of the Military Services infected with HIV and for prevention activities to control transmission of HIV.

2. APPLICABILITY. This instruction applies to OSD, the Military Departments, 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.

3. POLICY. It is DoD policy to:

a. Deny eligibility for military service to persons with laboratory evidence of HIV infection for appointment, enlistment, pre-appointment, or initial entry training for military service pursuant to DoDI 6130.03 (Reference (c)).

b. Periodically screen Service members for HIV infection.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. RELEASABILITY. **Unlimited**. This instruction is approved for public release and is available on the Internet from the DoD Issuances Website at http://www.dtic.mil/whs/directives.

7. EFFECTIVE DATE. This instruction:

a. Is effective June 7, 2013.

b. Must be reissued, cancelled, or certified current within 5 years of its publication in accordance with DoDI 5025.01 (Reference (d)). If not, it will expire effective June 7, 2023 and be removed from the DoD Issuances Website.

Jessica L. Wright
Acting Under Secretary of Defense for
Personnel and Readiness

Enclosures
1. References
2. Responsibilities
3. Procedures

Glossary

TABLE OF CONTENTS

ENCLOSURE 1

REFERENCES

(a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(b) DoD Instruction 6485.01, "Human Immunodeficiency Virus," October 17, 2006 (hereby cancelled)
(c) DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
(d) DoD Instruction 5025.01, "DoD Directives Program," September 26, 2012
(e) DoD Directive 6490.02E, "Comprehensive Health Surveillance," February 8, 2012
(f) DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," January 3, 2006
(g) DoD Instruction 6490.03, "Deployment Health," August 11, 2006
(h) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011
(i) DoD 6025.13-R, "Military Health System (MHS) Clinical Quality Assurance Program (CQA) Regulation," June 11, 2004
(j) DoD Instruction 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010
(k) DoD Instruction 1332.38, "Physical Disability Evaluation," November 14, 1996, as amended
(l) Section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986
(m) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
(n) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003

ENCLOSURE 2

RESPONSIBILITIES

1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R) provides overall policy implementation guidance for:

a. The personnel management of Service members with laboratory evidence of HIV infection.

b. Compliance with host-nation requirements for screening and related matters for Service members.

2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). Under the authority, direction, and control of the USD(P&R), the ASD(HA) provides overall policy implementation guidance for the medical management of Service members with laboratory evidence of HIV infection and for health education programs to prevent the transmission of HIV.

3. UNDER SECRETARY OF DEFENSE FOR POLICY (USD(P)). The USD(P):

a. Identifies or confirms host-nation HIV screening and other related requirements and transmits this information to the USD(P&R).

b. Coordinates matters involving host-nation screening and other related requirements with the Department of State.

4. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments:

a. Implement this instruction and any guidance issued under the authority of this instruction.

b. Report HIV test results to the Defense Medical Surveillance System pursuant to DoDD 6490.02E (Reference (e)).

c. Direct health care personnel providing medical care to follow the recommendations of the Centers for Disease Control and Prevention for preventing HIV transmission in health-care settings.

ENCLOSURE 3

PROCEDURES

1. TESTING AND SCREENING

a. Applicants for appointment, enlistment, or individuals being inducted into the Military Services will be screened for laboratory evidence of HIV infection in accordance with Reference (c).

b. Applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs will be tested for laboratory evidence of HIV within 72 hours of arrival to the program and denied entry to the program if such test is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV not later than during their commissioning physical examination, and denied a commission if they test positive.

c. All Service members will be screened periodically for laboratory evidence of HIV infection.

(1) Active duty (AD) and Reserve Component (RC) Selected Reserve (SELRES) personnel will be routinely screened every 2 years unless more frequent screenings are clinically indicated.

(2) Members of the SELRES will be screened at least once every 2 years. RC personnel will be screened when called to a period of AD greater than 30 days if they have not received an HIV test within the last 2 years.

(3) Testing for laboratory evidence of HIV for pre- and post-deployment must be conducted in accordance with DoDI 6025.19 (Reference (f)) and DoDI 6490.03 (Reference (g)).

d. A serum sample from all HIV force screenings will be forwarded to the DoD Serum Repository as directed by Reference (e).

2. MANAGEMENT

a. Clinical management of an AD Service member and an RC Service member on AD for a period of more than 30 days with laboratory evidence of HIV infection will be conducted consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines, as described in DoDI 6025.13 and DoD 6025.13-R (References (h) and (i)).

b. In accordance with DoDI 6490.07 (Reference (j)), the cognizant Combatant Command surgeon will be consulted in all instances of HIV seropositivity before medical clearance for deployment.

c. An AD Service member with laboratory evidence of HIV infection will be referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses in accordance with DoDI 1332.38 (Reference (k)). An AD Service member with laboratory evidence of HIV infection determined to be fit for duty will be allowed to serve in a manner that ensures access to appropriate medical care.

d. An RC Service member with laboratory evidence of HIV infection will be referred for a medical evaluation of fitness for continued service in accordance with Service regulations, and in the same manner as an RC Service member with other chronic or progressive illnesses. Eligibility for active duty for a period of more than 30 days will be denied to those RC Service members with laboratory evidence of HIV infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). RC Service members who are not on active duty for a period of more than 30 days or who are not on full-time National Guard duty, and who show laboratory evidence of HIV infection, will be transferred involuntarily to the Standby Reserve only if they cannot be used in the SELRES.

e. AD and RC Service members with laboratory evidence of HIV infection who are determined to be unfit for further duty will be separated or retired pursuant to Reference (k).

3. TRANSMISSION CONTROL. Transmission of HIV will be controlled through aggressive disease surveillance and health education programs for Service members. A Service member with laboratory evidence of HIV infection will receive training on the prevention of further transmission of HIV infection to others and the legal consequences of exposing others to HIV infection.

4. ADVERSE PERSONNEL ACTION. Information obtained during or primarily as a result of an epidemiologic assessment interview will not be used to support any adverse personnel action against the Service member in accordance with section 705(c) of Public Law 99-661 (Reference (l)). This prohibition does not apply to the use of such information for otherwise authorized rebuttal or impeachment purposes.

5. PRIVACY. The privacy of a Service member with laboratory evidence of HIV infection will be protected consistent with DoD 5400.11-R and DoD 6025.18-R (References (m) and (n)).

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AD	active duty
ASD(HA)	Assistant Secretary of Defense for Health Affairs
DoDD	DoD Directive
DoDI	DoD Instruction
HIV	human immunodeficiency virus
RC	Reserve Component
SELRES	Selected Reserves
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USD(P)	Under Secretary of Defense for Policy

PART II. DEFINITIONS

These terms and their definitions are for the purposes of this instruction.

adverse personnel action. A court-martial, non-judicial punishment, involuntary separation for other than medical reasons, administrative or punitive reduction in grade, denial of promotion, an unfavorable entry in a personnel record (other than an accurate entry concerning an action that is not an adverse personnel action), or a bar to reenlistment other than for medical reasons.

epidemiologic assessment interview. Questioning of a Service member who has been confirmed by DoD to have laboratory evidence of HIV infection for purposes of medical treatment or counseling or for epidemiologic or statistical purposes.

HIV. The virus(es) associated with the acquired immune deficiency syndrome (commonly referred to as "AIDS").

laboratory evidence of HIV infection. A reactive and confirmed serologic result, and/or, reactive or quantitative nucleic acid result for HIV infection according to a Food and Drug Administration-approved test.

EXHIBIT 3

Army Regulation 40–501

Medical Services

Standards of Medical Fitness

Headquarters
Department of the Army
Washington, DC
14 June 2017

UNCLASSIFIED

SUMMARY of CHANGE

AR 40–501
Standards of Medical Fitness

This mandated revision, dated 14 June 2017—

- Implements Secretary of the Army Memorandum for the Commander, U.S. Army Cadet Command, dated 21 April 2016, and Secretary of the Army Memorandum for the Superintendent, U.S. Military Academy, dated 6 Nov 2015, allowing the Cadet Command and the Military Academy to be waiver authorities (paras 1–6*c*(1), 1–6*c*(2), and 1–6*e*).

- Implements the National Defense Authorization Act, Fiscal Year 2017, Section 524 amendment to 10 USC 1177, to include medical examination for sexual assault victims prior to separation from the Army (para 8–24*a*(3)).

Headquarters
Department of the Army
Washington, DC
14 June 2017

*Army Regulation 40–501

Effective 14 June 2017

Medical Services

Standards of Medical Fitness

By Order of the Secretary of the Army:

MARK A. MILLEY
General, United States Army
Chief of Staff

Official:

GERALD B. O'KEEFE
Administrative Assistant to the Secretary of the Army

History. This publication is a mandated revision.

Summary. This publication implements 10 USC 1177, DODD 6130.3, DODI 6130.4, and AD 2016–30. It provides information on medical fitness standards for induction, enlistment, appointment, retention, and related policies and procedures. The publication of this mandated revision does not rescind or supersede policy changes to this regulation found in Army directives existing at the time of this publication.

Applicability. This regulation applies to the active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. It also applies to candidates for military service. During mobilization, the proponent may modify chapters and policies contained in this regulation. The publication of this mandated revision does not rescind or supersede policy changes to this regulation found in Army directives existing at the time of this publication.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activities senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army internal control process. This regulation contains internal control provisions and identifies key internal controls that must be evaluated (see appendix B).

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from The Surgeon General (DASG–HS–AS), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Office of The Surgeon General (DASG–HS–AS), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for medical activities only of the active Army, the Army National Guard of the United States, and the U.S. Army Reserve.

Contents (Listed by paragraph and page number)

*This regulation supersedes AR 40–501, dated 22 December 2016.

UNCLASSIFIED

Contents—Continued

Contents—Continued

Contents—Continued

Contents—Continued

Contents—Continued

Contents—Continued

DX030

Chapter 1
General Provisions

1–1. Purpose

This regulation governs—

a. Medical fitness standards for enlistment, induction, and appointment, including officer procurement programs.

b. Medical fitness standards for retention and separation, including retirement.

c. Medical fitness standards for diving, Special Forces, Airborne, Ranger, free fall parachute training and duty, and certain enlisted military occupational specialties (MOSs) and officer assignments.

d. Medical standards and policies for aviation.

e. Physical profiles.

f. Medical examinations and periodic health assessments.

1–2. References

See appendix A.

1–3. Explanation of abbreviations and terms

See the glossary.

1–4. Responsibilities

a. The Surgeon General (TSG) will develop, revise, interpret, and disseminate current Army medical fitness standards and ensure Army compliance with Department of Defense (DOD) directives pertaining to those standards. TSG has the authority to issue exceptions to policies that are contained in this regulation.

b. Director, Department of Defense Medical Examination Review Board (DODMERB); Director, Army National Guard; Chief, U.S. Army Reserve (USAR); Superintendent, U.S. Military Academy (USMA), Director, Uniformed Services University of the Health Sciences (USUHS), and commanders of the U.S. Military Entrance Processing Command (MEPCOM), U.S. Army Recruiting Command (USAREC), U.S. Training and Doctrine Command, U.S. Army Medical Command (USAMEDCOM), U.S. Army Human Resources Command (AHRC), State Adjutants General, and all Army military treatment facilities (MTFs) worldwide, will implement policies prescribed in this regulation applicable to all Active Army and Reserve Component (RC) personnel and applicants for appointment (including all officer procurement programs), enlistment, and induction.

c. Commanders and military personnel officers at all levels of command will implement administrative and command provisions of chapters 5, 7, 8, 9, 10, and 11.

1–5. Medical classification

Individuals evaluated under the medical fitness standards contained in this regulation will be reported as indicated below.

a. *Medically acceptable.* Medical examiners will report as "medically acceptable" all individuals who meet the medical fitness standards established for the particular purpose for which examined. No individual will be accepted on a provisional basis subject to the successful treatment or correction of a disqualifying defect.

b. *Medically unacceptable.*

(1) Medical examiners will report as "medically unacceptable" by reason of medical unfitness all individuals who possess any one or more of the medical conditions or physical defects listed in this regulation as a cause for rejection for the specific purpose for which examined, except as noted in (2), below.

(2) Medical examiners will report as "Medically unacceptable—prior administrative waiver granted" all individuals who do not meet the medical fitness standards established for the particular purpose for which examined when a waiver has been previously granted and the applicable provisions of paragraph 1–6 apply.

1–6. Review authorities and waivers

a. Medical fitness standards cannot be waived by medical examiners or by the examinee.

b. Examinees initially reported as medically unacceptable by reason of medical unfitness when the medical fitness standards in chapter 2, 3, 4, or 5 apply, may request a waiver of the medical fitness standards in accordance with the basic administrative directive governing the personnel action. Upon such request, the designated administrative authority or his or her designees for the purpose may grant such a waiver in accordance with current directives. The Office of the Surgeon

General provides guidance when necessary to the review and waiver authorities on the interpretation of the medical standards and appropriateness of medical waivers. The Secretary of the Army is the waiver authority for accession. That authority is delegated down through the Deputy Chief of Staff, G–1 to the authorities listed in paragraphs *c* through *i*, below.

c. The DODMERB, U.S. Air Force Academy, Colorado Springs, CO 80840–6518 is the sole review authority for reports of examinations given applicants for contracting into the Reserve Officers' Training Corps (ROTC) Programs. (See AR 40–29/NAVMEDCOMINST 6120.2/AFR 160–13/CG COMDTINST M6120.8.) Military Entrance Processing Stations (MEPS) under the purview of MEPCOM, are the review authorities for non-scholarship ROTC program examinations accomplished in their facilities. However, non-scholarship applicants who desire to contract into the ROTC program must have a qualifying DODMERB Review.

(1) The waiver authority for entry into ROTC programs, continuation in advances courses, and commissioning of ROTC participants, to include the Green to Gold program, is the Commanding General, United States Army Cadet Command (USACC). The CG, USACC may delegate this waiver authority to the USACC brigade commanders, but no further delegation is authorized. If such authority is delegated, USACC brigade commanders will consult with the USACC Command Surgeon before approving any medical waivers. In those cases where the brigade commander non-concurs with the USACC Command Surgeon's recommendation, the approval authority will revert to the CG, USACC. The approval authority for any medical disqualification for scholarship candidates resides solely with the CG, USACC and cannot be further delegated.

(2) The waiver authority for applicants to USMA is the Superintendent, USMA. The waiver authority for commissioning USMA cadets is the Superintendent, USMA, following consultation with the Surgeon, USMA.

d. Military Entrance Processing Stations (MEPS), under the purview of MEPCOM, are the review authorities for original enlistment examinations accomplished in their facilities. The Commanding General, USAREC, is the waiver authority for original enlistment. The Director, Army National Guard is the waiver authority for the Army National Guard (ARNG) and the Army National Guard of the United States (ARNGUS).

e. The waiver authority for direct accessions to Officer Candidate School (OCS) is the CG, USAREC. The waiver authority for currently serving enlisted Soldiers ("In-service") applicants to OCS is DCS, G–1. The application for a medical waiver to OCS will include a medical recommendation on the medical waiver from a military physician or military treatment facility (MTF) physician regarding any potential physical limitations or medical conditions and their possible impact upon an OCS applicant's ability to function as a military officer.

f. Review and waiver authority for other direct appointment programs (for example, Chaplain Corps) is USAREC. The waiver authority for initial selection for the Judge Advocate General Corps is AHRC.

g. Waiver authority for Special Forces training, Special Forces Assessment and Selection (SFAS), survival, evasion, resistance, escape (SERE) training, Military Freefall (MFF), and Special Forces Combat Diving Qualification Course (CDQC) is the Commandant, U.S. Army John F. Kennedy Special Warfare Center and School (USAJFKSWCS). Waiver authority for the Airborne School is the Commandant, U.S. Army Infantry School in coordination with AHRC.

h. Waivers for initial enlistment or appointment, including entrance and retention in officer procurement programs, will not be granted if the applicant does not meet the retention standards of chapter 3. Requests from waiver authorities for exception to this policy will only be made under extraordinary circumstances and only with the approval of TSG (Headquarters, Department of the Army, (HQDA) (DASG–HS–AS)).

i. Waivers of medical fitness standards that have been previously granted apply automatically to subsequent medical actions pertinent to the program or purpose for which granted without the necessity of confirmation or termination when—

(1) The duration of the waiver was not limited at the time it was granted and the medical condition or physical defect has not interfered with the individual's successful performance of military duty.

(2) The medical condition or physical defect waived was below retention medical fitness standards applicable to the particular program involved and the medical condition or physical defect has remained essentially unchanged.

(3) The medical condition or physical defect waived was below procurement medical fitness standards applicable to the particular program involved and the medical condition or physical defect, although worse, is within the retention medical fitness standards prescribed for the program or purpose involved.

j. Exception to accession waiver for hearing: For waivers of hearing standards that are determined upon further testing to be worse than initially evaluated and will interfere with the individual's successful performance of military duty, the Soldier may be separated from military Service within the first 180 days for an existing prior to Service (EPTS) medical condition, provided an audiologist, entrance physical standards board (EPSBD), or medical board determines that no Service related cause or aggravation made the hearing worse than when initially evaluated.

Chapter 2
Physical Standards for Enlistment, Appointment, and Induction

2–1. General

This chapter implements DODD 6130.3, Physical Standards for Appointment, Enlistment, and Induction, December 15, 2000, and DODI 6130.4, Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces, January 18, 2005.

2–2. Application and responsibilities

a. *Purpose.* The purpose of the standards contained in this chapter is to ensure that individuals medically qualified are—

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

(2) Free of medical conditions or physical defects that would require excessive time lost from duty for necessary treatment or hospitalization or would likely result in separation from the Army for medical unfitness.

(3) Medically capable of satisfactorily completing required training.

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

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

b. *Application.* This chapter prescribes the medical conditions and physical defects that are causes for rejection for appointment, enlistment, and induction into military Service. Unless otherwise stipulated, the conditions listed in this chapter are those that would be disqualifying by virtue of current diagnosis, or for which the candidate has a verified past medical history. Other standards may be prescribed by DOD in the event of mobilization or a national emergency. Those individuals found medically qualified based on the medical standards of chapter 2 that were in effect prior to this publication will not be disqualified solely on the basis of the new standards. The designated waiver authorities may grant waivers for selection or continuation in the programs described below, provided the individual meets the retention standards of chapter 3. However, the standard in paragraph 2–30*a* will not be waived regardless of whether chapter 2 or chapter 3 standards are applied.

c. *Scope.* The standards of chapter 2 apply to—

(1) Applicants for appointment as commissioned or warrant officers in the Active Army and RC, including appointment as a Soldier in the USAR or the ARNG/ARNGUS. This includes enlisted Soldier applicants for appointment as commissioned or warrant officers. (However, for officers of the ARNG/ARNGUS or USAR who apply for appointment in the Active Army, the standards of chap 3 are applicable.)

(2) Applicants for enlistment in the Active Army, including the Delayed Entry/Future Soldier Program (delayed entry program). For medical conditions or physical defects predating original enlistment, these standards are applicable for enlistees' first 6 months of active duty. (However, for enlisted Soldiers of the ARNG/ARNGUS or USAR who apply for enlistment in the Active Army or who re-enter active duty for training (ADT) under the "split-training" option, the standards of chapter 3 are applicable.)

(a) Enlisted Soldiers identified within the first 6 months of active duty with a condition that existed prior to service that does not meet the standards of chapter 2 may be separated (or receive a waiver to remain on active duty) following an evaluation by an Entrance Physical Standards Board, in accordance with AR 635–200, chapter 5, with the exception as noted in *(b)*, below.

(b) Enlisted Soldiers identified within the first 6 months of active duty with a condition that existed prior to service that does not meet the standards of chapter 2 or chapter 3 must be evaluated by a medical evaluation board (MEB). The Soldier will then be referred to a physical evaluation board (PEB) unless the Soldier waives their right to the PEB in accordance with AR 635–40.

(3) Applicants for enlistment in the RC and Federally recognized units or organizations of the ARNG/ARNGUS. For medical conditions or physical defects predating original enlistment, these standards are applicable during the enlistees' initial period of ADT.

(4) Applicants for reenlistment in the Active Army, RC, and ARNG/ARNGUS after a period of more than 6 months has elapsed since discharge.

(5) Applicants (civilian applicants or enlisted Soldier applicants) for the USMA, Scholarship or Advanced Course ROTC, USUHS, Health Professions Scholarship Program (HPSP), Officer Candidate School (OCS), Warrant Officer Candidate School, and all other Army special officer personnel procurement programs. (See chap 3 for retention of students in HPSP and USUHS programs.)

(6) Retention of cadets and midshipmen at the U.S. Armed Forces academies and students enrolled in ROTC. (However, the Commander, ROTC Cadet Command or the Superintendent, USMA has the authority to grant medical waivers for continuation in these programs, provided the cadet meets the retention standards of chap 3.)

(7) All individuals being inducted into the Army.

d. *Responsibilities.* The Secretary of the Army will—

(1) Revise Army policies to conform to the standards contained in DOD Directive 6130.3 and DOD Instruction 6130.4.

(2) Ensure uniformity of application and implementation of DOD Instruction 6130.4.

(3) Have authority to grant a waiver of the standards in individual cases for applicable reasons and ensure uniformity of waiver determinations. Delegated waiver authorities are noted in chapter 1.

(4) Have authority to change Army-specific visual standards (particularly for officer-accession programs) and establish other standards for special programs. Notification of any proposed changes in standards will be provided to the ASD(HA) 60 days before their implementation.

(5) Ensure that accurate International Classification of Disease (ICD) Codes are assigned to all medical conditions resulting in a personnel action such as medical waiver or medical separation.

(6) Eliminate inconsistencies and inequities based on race, sex, or examination location in the application of the standards.

e. *Medical conditions.* The disqualifying medical conditions are listed in paragraphs 2–3 through 2–32, below. (The ICD codes are listed in parentheses following each standard in chap 2.) Unless otherwise stipulated, the conditions listed in paragraphs 2–3 through 2–32, below, are those that would be disqualifying by virtue of current diagnosis, or for which the candidate has a verified past medical history.

2–3. Abdominal organs and gastrointestinal system

a. *Esophagus.* Current or history of esophageal disease, including, but not limited to ulceration, varices, fistula, achalasia, or Gastro-Esophageal Reflux Disease (GERD) (530.81), or complications from GERD including stricture, or maintenance on acid suppression medication, or other dysmotility disorders; chronic, or recurrent esophagitis (530.1), does not meet the standard. Current or history of reactive airway disease associated with GERD does not meet the standard. Current or history of dysmotility disorders, chronic, or recurrent esophagitis (530) does not meet the standard. History of surgical correction for GERD within 6 months does not meet the standard. (P42 esophageal correction, P43 stomach correction and P45 intestinal correction.)

b. Stomach and duodenum.

(1) Current gastritis, chronic or severe (535), or non-ulcerative dyspepsia that requires maintenance medication does not meet the standard.

(2) Current ulcer of stomach or duodenum confirmed by x-ray or endoscopy (533) does not meet the standard.

(3) History of surgery for peptic ulceration or perforation does not meet the standard.

c. Small and large intestine.

(1) Current or history of inflammatory bowel disease, including, but not limited to unspecified (558.9), regional enteritis or Crohn's disease (555), ulcerative colitis (556), or ulcerative proctitis (556), does not meet the standard.

(2) Current or history of intestinal malabsorption syndromes, including, but not limited to post-surgical and idiopathic (579), does not meet the standard. Lactase deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with normal function.

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

(4) Current or history of irritable bowel syndrome (564.1) of sufficient severity to require frequent intervention or to interfere with normal function does not meet the standard.

(5) History of bowel resection does not meet the standard.

(6) Current symptomatic diverticular disease of the intestine does not meet the standard.

d. *Gastrointestinal bleeding.* History of gastrointestinal bleeding (578), including positive occult blood (792.1) if the cause has not been corrected, does not meet the standard. Meckel's diverticulum (751.0), if surgically corrected greater than 6 months prior, is not disqualifying.

e. Hepatic-biliary tract.

(1) Current acute or chronic hepatitis, hepatitis carrier state (070), hepatitis in the preceding 6 months, or persistence of symptoms after 6 months, or objective evidence of impairment of liver function does not meet the standard.

(2) Current or history of cirrhosis (571), hepatic cysts (573.8), abscess (572.0), or sequelae of chronic liver disease (571.3) does not meet the standard.

(3) Current or history of symptomatic cholecystitis, acute or chronic, with or without cholelithiasis (574), postcholecystectomy syndrome, or other disorders of the gallbladder, and biliary system (576) do not meet the standard. Cholecystectomy is not disqualifying if performed greater than 6 months prior to examination and patient remains asymptomatic.

Fiberoptic procedure to correct sphincter dysfunction or cholelithiasis if performed greater than 6 months prior to examination and patient remains asymptomatic may not be disqualifying.

(4) Current or history of pancreatitis, acute (577.0) or chronic (577.1), does not meet the standard.

(5) Current or history of metabolic liver disease, including, but not limited to hemochromatosis (275.0), Wilson's disease (275.1), or alpha-1 anti-trypsin deficiency (277.6), does not meet the standard.

(6) Current enlargement of the liver from any cause (789.1) does not meet the standard.

f. Anorectal.

(1) Current anal fissure or anal fistula (565) does not meet the standard.

(2) Current or history of anal or rectal polyp (569.0), prolapse (569.1), stricture (569.2), or fecal incontinence (787.6) within the last 2 years does not meet the standard.

(3) Current hemorrhoid (internal or external), when large, symptomatic, or with a history of bleeding (455) within the last 60 days, does not meet the standard.

g. Spleen.

(1) Current splenomegaly (789.2) does not meet the standard.

(2) History of splenectomy (P41.5) does not meet the standard, except when resulting from trauma.

h. Abdominal wall.

(1) Current hernia, including, but not limited to uncorrected inguinal (550) and other abdominal wall hernias (553), do not meet the standard.

(2) History of open or laparoscopic abdominal surgery during the preceding 6 months (P54) does not meet the standard.

i. *Other.* History of any gastrointestinal procedure for the control of obesity does not meet the standard. Artificial openings, including, but not limited to ostomy (V44), do not meet the standard.

2–4. Blood and blood-forming tissue diseases

a. *Anemia.* Current hereditary or acquired anemia, which has not been corrected with therapy before appointment or induction, does not meet the standard. For the purposes of this regulation, anemia is defined as hemoglobin of less than 13.5 for males and less than 12 for females. The following ICD–9 codes are used for diagnosed anemia: hereditary hemolytic anemia (282), sickle cell disease (282.6), acquired hemolytic anemia (283), aplastic anemia (284), or unspecified anemias (285).

b. *Hemorrhagic disorders.* Current or history of coagulation defects (286) to include, but not limited to von Willebrand's Disease (286.4), idiopathic thrombocytopenia (287), or Henoch-Schönlein Purpura (287.0), does not meet the standard.

c. *Leukopenia*. Current or history of diagnosis of any form of chronic or recurrent agranulocytosis and/or leukopenia (288.0) does not meet the standard.

2–5. Dental

a. Current diseases of the jaws or associated tissues that prevent normal functioning do not meet the standard. Those diseases include, but are not limited to temporomandibular disorders (524.6) and/or myofascial pain that have not been corrected.

b. Current severe malocclusion (524), which interferes with normal mastication or requires early and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement does not meet the standard.

c. Current insufficient natural healthy teeth (521) or lack of a serviceable prosthesis that prevents adequate incision and mastication of a normal diet and/or includes complex (multiple fixtures) dental implant systems with associated complications do not meet the standard. Individuals undergoing endodontic care are acceptable for entry in the Delayed Entry Program only if a civilian or military provider provides documentation that active endodontic treatment will be completed prior to being sworn into active duty.

d. Current orthodontic appliances for continued treatment (V53.4) do not meet the standard. Retainer appliances are permissible, provided all active orthodontic treatment has been satisfactorily completed. Individuals undergoing orthodontic care are acceptable for enlistment in the Delayed Entry Program only if a civilian or military orthodontist provides documentation that active orthodontic treatment will be completed prior to being sworn into active duty.

2–6. Ears

a. *External ear.* Current atresia (744.02) or severe microtia (744.23), congenital or acquired stenosis (380.5), chronic otitis externa (380.2), or severe external ear deformity (744.3) that prevents or interferes with the proper wearing of hearing protection does not meet the standard.

b. *Mastoids.* Current or history of mastoiditis (383.9), residual with fistula (383.81), chronic drainage or conditions requiring frequent cleaning of the mastoid bone do not meet the standard. Marked external deformity that prevents or interferes with wearing a protective mask or helmet (383.3) does not meet the standard.

c. *Ménière's syndrome.* Current or history of Ménière's syndrome or other chronic diseases of the vestibular system (386) does not meet the standard.

d. *Middle and inner ear.* Current or history of chronic otitis media (382), cholesteatoma (385.3), or history of any inner (P20) or middle (P19) ear surgery (including cochlear implantation) does not meet the standard. Myringotomy or successful tympanoplasty is not disqualifying.

e. *Tympanic membrane.* Current perforation of the tympanic membrane (384.2) or history of surgery to correct perforation during the preceding 120 days (P19) does not meet the standard.

2–7. Hearing

a. Audiometers, calibrated to standards of the International Standards Organization (ISO 8253:1 1989) (reference (c)) or the American National Standards Institute (ANSI 1996), will be used to test the hearing of all applicants.

b. All audiometric tracings or audiometric readings recorded on reports of medical examination or other medical records will be clearly identified.

c. Current hearing threshold level in either ear greater than that described below does not meet the standard:

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

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

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

d. Current or history of hearing aid use (V53.2) does not meet the standard.

2–8. Endocrine and metabolic disorders

a. Current or history of adrenal dysfunction (255) does not meet the standard.

b. Current or history of diabetes mellitus (250) does not meet the standard.

c. Current persistent glycosuria when associated with impaired glucose tolerance (250) or renal tubular defects (271.4) does not meet the standard.

d. Current or history of acromegaly, including, but not limited to gigantism or other disorders of pituitary function (253), does not meet the standard.

e. Current or history of gout (274) does not meet the standard.

f. Current or history of hyperinsulinism (251.1) does not meet the standard.

g. Current or history of hyperparathyroidism (252.0) and hypoparathyroidism (252.1) does not meet the standard.

h. Thyroid disorders.

(1) Current goiter (240) does not meet the standard.

(2) Current hypothyroidism uncontrolled by medication (244) does not meet the standard.

(3) Current or history of hyperthyroidism (242.9) does not meet the standard.

(4) Current thyroiditis (245) does not meet the standard.

i. Current nutritional deficiency diseases, including, but not limited to beriberi (265), pellagra (265.2), and scurvy (267) do not meet the standard.

j. Other endocrine or metabolic disorders such as cystic fibrosis (277), porphyria (277.1), and amyloidosis (277.3) that obviously prevent satisfactory performance of duty or require frequent or prolonged treatment do not meet the standard.

2–9. Upper extremities

a. *Limitation of motion.* Current joint ranges of motion less than the measurements listed below do not meet the standard.

(1) Shoulder (726.1):

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) Elbow (726.3):

(a) Flexion to 100 degrees.

(b) Extension to 15 degrees.

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

(4) Hand (726.4):

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

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

b. Hand and fingers.

(1) Current absence of the distal phalanx of either thumb (885) does not meet the standard.

(2) Current absence of distal and middle phalanx of an index, middle, or ring finger of either hand, irrespective of the absence of the little finger (886), does not meet the standard.

(3) Current absence of more than the distal phalanx of any two of the following fingers: index, middle finger, or ring finger of either hand (886) does not meet the standard.

(4) Current absence of hand or any portion thereof (887) does not meet the standard except for specific absences of fingers as noted above.

(5) Current polydactyly (755) does not meet the standard.

(6) Scars and deformities of the fingers or hand (905.2) that are symptomatic or that impair normal function to such a degree as to interfere with the satisfactory performance of military duty do not meet the standard (see also para 2–32).

(7) Current intrinsic paralysis or weakness of upper limbs, including nerve paralysis, carpal tunnel and cubital syndromes, lesion of ulnar and radial nerve (354) sufficient to produce physical findings in the hand, such as muscle atrophy and weakness does not meet the standard.

(8) Current disease, injury, or congenital condition with residual weakness or symptoms such as to prevent satisfactory performance of duty, including, but not limited to chronic joint pain: shoulder (719.41), upper arm (719.42), forearm (719.43), and hand (719.44), late effect of fracture of the upper extremities (905.2), late effect of sprains without mention of injury (905.7), and late effects of tendon injury (905.8) do not meet the standard. (See also para 2–11.)

2–10. Lower extremities

a. *Limitation of motion.* Current joint ranges of motion less than the measurements listed in paragraphs below do not meet the standard.

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

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

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

(d) Abduction to 45 degrees.

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

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

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

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

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(4) Subtalar eversion and inversion totaling 5 degrees (due to disease (726.7) or injury (905.4) or congenital defect).

b. Foot and ankle.

(1) Current absence of a foot or any portion thereof (896) does not meet the standard.

(2) Current or history of deformities of the toes (acquired (735) or congenital (755.66)) including, but not limited to conditions such as hallux valgus (735.0), hallux varus (735.1), hallux rigidicus (735.2), hammer toe(s) (735.4), claw toe(s) (735.5), overriding toe(s) (735.8), that prevents the proper wearing of military footwear or impairs walking, marching, running, or jumping, do not meet the standard.

(3) Current or history of clubfoot (754.70) or pes cavus (754.71) that prevents the proper wearing of military footwear or impairs walking, marching, running, or jumping does not meet the standard.

(4) Current symptomatic pes planus (acquired (734) or congenital (754.6)) or history of pes planus corrected by prescription or custom orthotics does not meet the standard.

(5) Current ingrown toenails (703.0), if infected or symptomatic, do not meet the standard.

(6) Current plantar fasciitis (728.71) does not meet the standard.

(7) Current neuroma (355.6) that is refractory to medical treatment, or impairs walking, marching, running, or jumping, or prevents the proper wearing of military footwear, does not meet the standard.

c. Leg, knee, thigh, and hip.

(1) Current loose or foreign body within the knee joint (717.6) does not meet the standard.

(2) History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury does not meet the standard. History of surgical correction of knee ligaments does not meet the standard only if symptomatic or unstable (P81.4).

(3) Current symptomatic medial and lateral collateral ligament injury does not meet the standard.

(4) Current symptomatic medial and lateral meniscal injury does not meet the standard.

(5) Current unspecified internal derangement of the knee (717.9) does not meet the standard.

(6) Current or history of congenital dislocation of the hip (754.3), osteochondritis of the hip (Legg-Perthes disease) (732.1), or slipped femoral epiphysis of the hip (732.2) does not meet the standard.

(7) Current or history of hip dislocation (835) within 2 years preceding examination does not meet the standard.

(8) Current osteochondritis of the tibial tuberosity (Osgood-Schlatter disease) (732.4), does not meet the standard if symptomatic.

d. General.

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh (719.45), lower leg (719.46), ankle and/or foot (719.47) that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life, or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty, do not meet the standard.

(2) Current leg-length discrepancy resulting in a limp (736.81) does not meet the standard. (See also para 2–11.)

2–11. Miscellaneous conditions of the extremities

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

b. Current joint dislocation if unreduced, or history of recurrent dislocations of any major joint such as shoulder (831), hip (835), elbow (832), knee (836), ankle (837), or instability of any major joint (shoulder (718.81), elbow (718.82), hip (718.85), ankle and foot (718.87) or multiple sites (718.89)) does not meet the standard. History of recurrent instability of the knee or shoulder does not meet the standard.

c. Current or history of chronic osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints of more than a minimal degree that has interfered with the following of a physically active vocation in civilian life, or that prevents the satisfactory performance of military duty does not meet the standard.

d. Fractures.

(1) Current malunion or non-union of any fracture (733.8) (except asymptomatic ulnar styloid process fracture) does not meet the standard.

(2) Current retained hardware that is symptomatic, interferes with proper wearing of protective equipment or military uniform, and/or is subject to easy trauma, does not meet the standard (V53.7). Retained hardware (733.99) (including plates, pins, rods, wires, or screws used for fixation) is not disqualifying if fractures are healed, ligaments are stable, there is no pain, and it is not subject to easy trauma.

e. Current devices, including, but not limited to silastic or titanium, implanted to correct orthopedic abnormalities (V43), do not meet the standard.

f. Current or history of contusion of bone or joint; an injury of more than a minor nature that will interfere or prevent performance of military duty, or will require frequent or prolonged treatment without fracture nerve injury, open wound, crush or dislocation, which occurred within the preceding 6 weeks (upper extremity (923), lower extremity (924), ribs and clavicle (922)) does not meet the standard.

g. History of joint replacement (V43.6) of any site does not meet the standard.

h. Current or history of muscular paralysis, contracture, or atrophy (728), if progressive or of sufficient degree to interfere with or prevent satisfactory performance of military duty or if it will require frequent or prolonged treatment, does not meet the standard.

i. Current osteochondritis dessicans (732.7) does not meet the standard.

j. Current or history of osteochondromatosis or multiple cartilaginous exostoses (727.82) do not meet the standard.

k. Current osteoporosis (733) does not meet the standard.

l. Current osteomyelitis (730), or history of recurrent osteomyelitis does not meet the standard. (See also paras 2–9 and 2–10.)

2–12. Eyes

a. Lids.

(1) Current blepharitis (373), chronic or acute, until cured (373.00), does not meet the standard.

(2) Current blepharospasm (333.81) does not meet the standard.

(3) Current dacryocystitis, acute or chronic (375.30) does not meet the standard.

(4) Deformity of the lids (374.4), complete or extensive lid deformity, sufficient to interfere with vision or impair protection of the eye from exposure does not meet the standard.

(5) Current growths or tumors of the eyelid, other than small, non-progressive, asymptomatic, benign lesions, do not meet the standard.

b. Conjunctiva.

(1) Current chronic conjunctivitis (372.1), including, but not limited to trachoma (076) and chronic allergic conjunctivitis (372.14), does not meet the standard.

(2) Current or recurrent pterygium, (372.4), if condition encroaches on the cornea in excess of 3 mm, or interferes with vision, or is a progressive peripheral pterygium (372.42), or recurring pterygium after two operative procedures (372.45), does not meet the standard.

(3) Current xerophthalmia (372.53) does not meet the standard.

c. Cornea.

(1) Current or history of corneal dystrophy of any type (371.5), including but not limited to keratoconus (371.6) of any degree does not meet the standard.

(2) History of refractive surgery including, but not limited to: Lamellar (P11.7) and/or penetrating keratoplasty (P11.6). Radial Keratotomy and Astigmatic Keratotomy does not meet the standard. Refractive surgery performed with an Excimer Laser, including but not limited to, Photorefractive Keratectomy (commonly known as PRK), Laser Epithelial Keratomileusis (commonly known as LASEK), and Laser-Assisted in situ Keratomileusis (commonly known as LASIK) (P11.7) does not meet the standard if any of the following conditions are met:

(a) Pre-surgical refractive error in either eye exceeds + 8.00 to - 8.00 diopters.

(b) At least 6 months recovery period has not occurred between last refractive surgery or augmenting procedure and accession medical examination.

(c) There have been complications, and/or medications or ophthalmic solutions are required.

(d) Post-surgical refraction in each eye is not stable as demonstrated by—

1. At least two separate refractions at least one month apart, the most recent of which demonstrates more than +/- 0.50 diopters difference for spherical vision and/or more than +/- 0.25 diopters for cylinder vision; and

2. At least 3 months recovery has not occurred between the last refractive surgery or augmenting procedure and one of the comparison refractions.

(e) Pre-surgical and post-surgical refractive error does not meet the standards for the military Service to which the candidate is applying.

(3) Current keratitis (370), acute or chronic, including, but not limited to recurrent corneal ulcers (370.0), erosions (abrasions), or herpetic ulcers (054.42) does not meet the standard.

(4) Current corneal vascularization (370.6) or corneal opacification (371) from any cause that is progressive or reduces vision below the standards prescribed in paragraph 2–13 does not meet the standard.

d. *Uveitis or iridocyclitis.* Current or history of uveitis or iridocyclitis (364.3) does not meet the standard.

e. Retina.

(1) Current or history of retinal defects and dystrophies, angiomatoses (759.6), retinoschisis and retinal cysts (361.1), phakomas (362.89), and other congenito-retinal hereditary conditions (362.7) that impair visual function or are progressive, do not meet the standard.

(2) Current or history of any chorioretinal or retinal inflammatory conditions, including, but not limited to conditions leading to neovascularization, chorioretinitis, histoplasmosis, toxoplasmosis, or vascular conditions of the eye to include Coats' disease, or Eales' disease (363) does not meet the standard.

(3) Current or history of degenerative changes of any part of the retina (362) does not meet the standard.

(4) Current or history of detachment of the retina (361), history of surgery for same, or peripheral retinal injury, defect (361.3), or degeneration that may cause retinal detachment does not meet the standard.

f. Optic nerve.

(1) Current or history of optic neuritis (377.3), including, but not limited to neuroretinitis, secondary optic atrophy, or documented history of retrobulbar neuritis does not meet the standard.

(2) Current or history of optic atrophy (377.1), or cortical blindness (377.75) does not meet the standard.

(3) Current or history of papilledema (377.0) does not meet the standard.

g. Lens.

(1) Current aphakia (379.31), history of lens implant, or current or history of dislocation of a lens does not meet the standard.

(2) Current or history of opacities of the lens (366) that interfere with vision or that are considered to be progressive, including cataract (366.9), do not meet the standard.

h. Ocular mobility and motility.

(1) Current diplopia (386.2) does not meet the standard.

(2) Current nystagmus (379.50) other than physiologic "end-point nystagmus" does not meet the standard.

(3) Esotropia (378.0), and hypertropia (378.31). For entrance into the USMA or ROTC programs, the following conditions are also disqualifying: esotropia of over 15 prism diopters; exotropia of over 10 prism diopters; hypertropia of over 5 prism diopters.

i. Miscellaneous defects and conditions.

(1) Current or history of abnormal visual fields due to disease of the eye or central nervous system (368.4), or trauma (368.9) does not meet the standard.

(2) Absence of an eye, clinical anophthalmos, unspecified congenital (743.00) or acquired, or current or history of other disorders of globe (360.8) does not meet the standard.

(3) Current asthenopia (368.13), does not meet the standard.

(4) Current unilateral or bilateral non-familial exophthalmos (376) does not meet the standard.

(5) Current or history of glaucoma (365), including, but not limited to primary, secondary, or pre-glaucoma as evidenced by intraocular pressure above 21 millimeters of mercury (mmHg), or changes in the optic disc or visual field loss associated with glaucoma, does not meet the standard.

(6) Current loss of normal pupillary reflex reactions to accommodation (367.5) or light (379.4), including Adie's syndrome, does not meet the standard.

(7) Current night blindness (368.6) does not meet the standard.

(8) Current or history of retained intraocular foreign body (360) does not meet the standard.

(9) Current or history of any organic disease of the eye (360) or adnexa (376) not specified above, which threatens vision or visual function, does not meet the standard.

2–13. Vision

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

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

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

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

b. However, for entrance into USMA or ROTC, distant visual acuity that does not correct to 20/20 in one eye and 20/40 in the other eye does not meet the standard. For entrance into OCS, distant visual acuity that does not correct to 20/20 in one eye and 20/100 in the other eye does not meet the standard.

c. Current near visual acuity (367) of any degree that does not correct to 20/40 in the better eye does not meet the standard.

d. Current refractive error (hyperopia (367.0), myopia (367.1), astigmatism (367.2)), or history of refractive error prior to any refractive surgery manifest by any refractive error in spherical equivalent of worse than -8.00 or +8.00 diopters does not meet the standard. However, for entrance into USMA or Army ROTC programs, the following conditions do not meet the standard:

(1) Astigmatism, all types over 3 diopters.

(2) Hyperopia over 8.00 diopters spherical equivalent.

(3) Myopia over 8 diopters spherical equivalent.

(4) Refractive error corrected by orthokeratology or keratorefractive surgery.

e. Contact lenses. Current complicated cases requiring contact lenses for adequate correction of vision, such as corneal scars (371) and irregular astigmatism (367.2), do not meet the standard.

f. Color vision (368.5). Failure to pass a color vision test is not an automatic disqualification. Although there is no standard, color vision will be tested because adequate color vision is a prerequisite for entry into many military specialties. However, for entrance into the USMA or Army ROTC or OCS programs, the inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or vivid green does not meet the standard.

2–14. Genitalia

a. Female genitalia.

(1) Current or history of abnormal uterine bleeding (626.2), including, but not limited to menorrhagia, metrorrhagia, or polymenorrhea, does not meet the standard.

(2) Current unexplained amenorrhea (626.0) does not meet the standard.

(3) Current or history of dysmenorrhea (625.3) that is incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities does not meet the standard.

(4) Current or history of endometriosis (617) does not meet the standard.

(5) History of major abnormalities or defects of the genitalia such as hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7), or dysfunctional residuals from surgical correction of these conditions does not meet the standard.

(6) Current or history of ovarian cysts (620.2), when persistent or symptomatic does not meet the standard.

(7) Current pelvic inflammatory disease (614), or history of recurrent pelvic inflammatory disease, does not meet the standard. Current or history of chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9) does not meet the standard.

(8) Current pregnancy (V22) does not meet the standard until 6 months after the end of the pregnancy.

(9) Uterus, congenital absence of (752.3), or enlargement due to any cause (621.2) does not meet the standard.

(10) Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.11) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function, does not meet the standard.

(11) Current abnormal gynecologic cytology, including, but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix (Pap smear) (795) excluding Human Papilloma Virus (HPV) (079.4) or confirmed Low-Grade Squamous Intraepithelial Lesion (LGSIL) (622.9), does not meet the standard. For the purposes of this regulation, confirmation is by colposcopy or repeat cytology.

b. Male genitalia.

(1) Current absence of one or both testicles, either congenital (752.89) or undescended (752.51) does not meet the standard.

(2) Current epispadias (752.62) or hypospadias (752.61), when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction, does not meet the standard.

(3) Current enlargement or mass of testicle or epididymis (608.9) does not meet the standard.

(4) Current orchitis (604) or epididymitis (604.90) does not meet the standard.

(5) History of penis amputation (878.0) does not meet the standard.

(6) Current or history of genital infection or ulceration, including, but not limited to herpes genitalis (054.13) and condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function, does not meet the standard

(7) Current acute prostatitis (601.0) or chronic prostatitis (601.1) does not meet the standard.

(8) Current hydrocele (603.0), if large or symptomatic, does not meet the standard. Left varicocele (456.4), if symptomatic, or associated with testicular atrophy, or vericocele larger than the testis does not meet the standard. Any right varicocele (456.4) does not meet the standard.

c. Current or history of chronic scrotal pain or unspecified symptoms associated with male genital organs (608.9) do not meet the standard.

d. History of major abnormalities or defects of the genitalia, such as hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7) or dysfunctional residuals from surgical correction of these conditions does not meet the standard.

2–15. Urinary system

a. Current cystitis (595), or history of chronic or recurrent cystitis does not meet the standard.

b. Current urethritis (597.80), or history of chronic or recurrent urethritis does not meet the standard.

c. History of enuresis (788.30) or incontinence of urine after 13th birthday does not meet the standard (see also para 2–29).

d. Current hematuria (599.7), pyuria, or other findings indicative of urinary tract disease (599) does not meet the standard.

e. Current urethral stricture (598) or fistula (599.1) does not meet the standard.

f. Kidney.

(1) Current absence of one kidney, congenital (753.0) or acquired (V45.73) does not meet the standard.

(2) Current pyelonephritis (chronic or recurrent) (590.0) or any other unspecified infections of the kidney (590.9) does not meet the standard.

(3) Current or history of polycystic kidney (753.1) does not meet the standard.

(4) Current or history of horseshoe kidney (753.3) does not meet the standard.

(5) Current or history of hydronephrosis (591) does not meet the standard.

(6) Current or history of acute (580) or chronic (582) nephritis of any type does not meet the standard.

g. Current or history of proteinuria (791.0) (greater than 200 milligrams (mg)/24 hours; or a protein to creatinine ratio greater than 0.2 in a random urine sample, if greater than 48 hours after strenuous activity) does not meet the standard, unless consultation determines the condition to be benign orthostatic proteinuria.

h. Current or history of urolithiasis (592) within the preceding 12 months does not meet the standard. Recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time, does not meet the standard.

2–16. Head

a. Uncorrected deformities of the skull, face, or mandible (754.0) of a degree that would prevent the individual from wearing a protective mask or military headgear do not meet the standard.

b. Loss or absence of the bony substance of the skull (756.0 or 738.1) not successfully corrected by reconstructive materials, or leaving residual defect in excess of 1 square inch (6.45 centimeter (cm)2) or the size of a 25 cent piece does not meet the standard.

2–17. Neck

a. Current symptomatic cervical ribs (756.2) do not meet the standard.

b. Current or history of congenital cysts (744.4) of branchial cleft origin or those developing from remnants of the thyroglossal duct, with or without fistulous tracts, does not meet the standard.

c. Current contraction (723) of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck, to the extent that it interferes with the proper wearing of a uniform or military equipment or is so disfiguring as to interfere with or prevent satisfactory performance of military duty, does not meet the standard.

2–18. Heart

a. Current or history of all valvular heart diseases, congenital (746) or acquired (394), including those improved by surgery, do not meet the standard. Mitral valve prolapse or bicuspid aortic valve is not disqualifying unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.

b. Current or history coronary heart disease (410) does not meet the standard.

c. Current or history of symptomatic arrhythmia or electrocardiographic evidence of arrhythmia.

(1) Current or history of supraventricular tachycardia (427.0), or any arrhythmia originating from the atrium or sinoatrial node, such as atrial flutter, and atrial fibrillation, unless there has been no recurrence during the preceding 2 years while off all medications, does not meet the standard. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or psychological impairment, do not meet the standard.

(2) Current or history of ventricular arrhythmias (427.1), including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions, does not meet the standard. Occasional asymptomatic unifocal premature ventricular contractions are not disqualifying.

(3) Current or history of ventricular conduction disorders, including, but not limited to disorders with left bundle branch block (426.2), Mobitz type II second degree atrioventricular (AV) block (426.12), and third degree AV block (426.0), and Lown-Ganong-Levine-Syndrome (426.81) associated with an arrhythmia do not meet the standard. Current or history of Wolff-Parkinson-White Syndrome (426.7), unless it has been successfully ablated for a period of 2 years without recurrence of arrhythmia and now with a normal electrocardiogram, does not meet the standard.

(4) Current or history of conduction disturbances such as first degree AV block (426.11), left anterior hemiblock (426.2), right bundle branch block (426.4), or Mobitz type I second degree AV block (426.13) do not meet the standard when symptomatic or associated with underlying cardiovascular disease.

d. Current cardiomegaly, hypertrophy, or dilatation of the heart (429.3) do not meet the standard.

e. Current or history of cardiomyopathy (425), including myocarditis (422), or congestive heart failure (428), does not meet the standard.

f. Current or history of pericarditis (420) (acute nonrheumatic), unless the individual is free of all symptoms for 2 years, and has no evidence of cardiac restriction or persistent pericardial effusion, does not meet the standard.

g. Current persistent tachycardia (785.1) (resting pulse rate of 100 beats per minute or greater) does not meet the standard.

h. Current or history of congenital anomalies of heart and great vessels (746), except for corrected patent ductus arteriosus, do not meet the standard.

2–19. Vascular system

a. Current or history of abnormalities of the arteries and blood vessels (447), including, but not limited to aneurysms (442), atherosclerosis (440), or arteritis (446), do not meet the standard.

b. Current or history of hypertensive vascular disease (401) does not meet the standard. Elevated blood pressure defined as the average of three consecutive sitting blood pressure measurements separated by at least 10 minutes, diastolic greater than 90 mmHg or three consecutive systolic pressure measurements greater than 140 mmHg does not meet the standard (796.2).

c. History of pulmonary (415) or systemic embolization (444) does not meet the standard.

d. Current or history of peripheral vascular disease (443), including, but not limited to diseases such as Raynaud's Disease (443.0) does not meet the standard.

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

2–20. Height

The causes for disqualification are—

a. Men: Height below 60 inches or over 80 inches does not meet the standard.

b. Women: Height below 58 inches or over 80 inches does not meet the standard.

2–21. Weight

a. Army applicants for initial appointment as commissioned officers (to include appointment as commissioned warrant officers) must meet the standards of AR 600–9. Body fat composition is used as the final determinant in evaluating an applicant's acceptability when the weight exceeds that listed in the weight tables.

b. All other applicants must meet the standards of tables 2-l and 2–2. Body fat composition is used as the final determinant in evaluating an applicant's acceptability when the weight exceeds that listed in the weight tables.

2–22. Body build

The cause for rejection for appointment, enlistment, and induction is deficient muscular development that would interfere with the completion of required training.

2–23. Lungs, chest wall, pleura, and mediastinum

a. Current abnormal elevation of the diaphragm, either side, does not meet the standard. Any nonspecific abnormal findings on radiological and other examination of body structure, such as lung field (793.1), or other thoracic or abdominal organ (793.2), does not meet the standard.

b. Current abscess of the lung or mediastinum (513) does not meet the standard.

c. Current or history of acute infectious processes of the lung, including but not limited to viral pneumonia (480), pneumococcal pneumonia (481), bacterial pneumonia (482), pneumonia other specified (483), pneumonia infectious disease classified elsewhere (484), bronchopneumonia organism unspecified (485), pneumonia organism unspecified (486), do not meet the standard until cured.

d. Asthma (493), including reactive airway disease, exercise-induced bronchospasm or asthmatic bronchitis, reliably diagnosed and symptomatic after the 13th birthday, does not meet the standard. Reliable diagnostic criteria may include any of the following elements: substantiated history of cough, wheeze, chest tightness, and/or dyspnea that persists or recurs over a prolonged period of time, generally more than 12 months.

e. Current bronchitis (490), acute or chronic, symptoms over 3 months occurring at least twice a year (491), does not meet the standard.

f. Current or history of bronchiectasis (494) does not meet the standard.

g. Current or history of bronchopleural fistula (510) unless resolved with no sequelae does not meet the standard.

h. Current or history of bullous or generalized pulmonary emphysema (492) does not meet the standard.

i. Current chest wall malformation (754), including, but not limited to pectus excavatum (754.81), or pectus carinatum (754.82), if these conditions interfere with vigorous physical exertion, does not meet the standard.

j. History of empyema (510) does not meet the standard.

k. Current pulmonary fibrosis (515) from any cause producing respiratory symptoms does not meet the standard.

l. Current foreign body in lung, trachea, or bronchus (934) does not meet the standard.

m. History of lobectomy (P32.4) does not meet the standard.

n. Current or history of pleurisy with effusion (511.9) within the previous 2 years does not meet the standard.

o. Current or history of pneumothorax (512) occurring during the year preceding examination, if due to trauma or surgery or occurring during the 3 years preceding examination from spontaneous origin, does not meet the standard Recurrent spontaneous pneumothorax (512) does not meet the standard.

p. History of open or laparoscopic thoracic or chest wall (including breasts) surgery during the preceding 6 months (P54) does not meet the standard.

2–24. Mouth

a. Current cleft lip or palate defects (749), not satisfactorily repaired by surgery do not meet the standard.

b. Current leukoplakia (528.6) does not meet the standard.

2–25. Nose, sinuses, and larynx

a. Rhinitis.

(1) Current allergic rhinitis (477.0), due to pollen (477.8), or due to other allergen, or cause unspecified (477.9), if not controlled by oral medication or topical corticosteroid medication, does not meet the standard. History of allergic rhinitis immunotherapy within the previous year does not meet the standard.

(2) Current chronic non-allergic rhinitis (472.0), if not controlled by oral medication or topical corticosteroid medication, does not meet the standard.

b. Current chronic conditions of larynx including vocal cord paralysis (478.3), chronic hoarseness, chronic laryngitis, larynx ulceration, polyps, granulation tissue, or other symptomatic disease of larynx, vocal cord dysfunction not elsewhere classified (478.7) do not meet the standard.

c. Current anosmia or parosmia (781.1) does not meet the standard.

d. History of recurrent epistaxis (784.7), with greater than one episode per week of bright red blood from the nose occurring over a 3-month period, does not meet the standard.

e. Current nasal polyps (471) or history of nasal polyps, unless greater than 12 months has elapsed since nasal polypectomy, does not meet the standard.

f. Current perforation of nasal septum (478.1) does not meet the standard.

g. Current chronic sinusitis (473), or current acute sinusitis (461.9), does not meet the standard. Such conditions exist when evidenced by chronic purulent nasal discharge, hyperplastic changes of the nasal tissue, symptoms requiring frequent medical attention, or x-ray findings.

h. Current or history of tracheostomy (V44.0) or tracheal fistula (530.84) does not meet the standard.

i. Current or history of deformities, or conditions or anomalies (750.9) of the upper alimentary tract, of the mouth, tongue, palate throat, pharynx, larynx, and nose that interfere with chewing, swallowing, speech, or breathing do not meet the standard.

j. Current chronic pharyngitis (462) and chronic nasopharyngitis (472.2), do not meet the standard.

2–26. Neurological disorders

a. Current or history of cerebrovascular conditions, including but not limited to subarachnoid (430) or intracerebral (431) hemorrhage, vascular insufficiency, aneurysm, or arteriovenous malformation (437), do not meet the standard.

b. History of congenital or acquired anomalies of the central nervous system (742), or meningocele (741.9), does not meet the standard.

c. Current or history of disorders of meninges, including, but not limited to cysts (349.2), does not meet the standard.

d. Current or history of degenerative and hereditodegenerative disorders, including, but not limited to those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), or peripheral nerves (337), do not meet the standard.

e. History of recurrent headaches (784.0), including, but not limited to, migraines (346) and tension headaches (307.81) that interfere with normal function in the past 3 years, or of such severity to require prescription medications, do not meet the standard.

f. Head injury (854.0).

(1) History of head injury will be disqualifying if associated with any of the following:

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

(b) Persistent motor or sensory deficits.

(c) Impairment of intellectual function.

(d) Alteration of personality.

(e) Unconsciousness, amnesia, or disorientation of person, place, or time of 24-hours duration or longer post-injury.

(f) Multiple fractures involving skull or face (804).

(g) Cerebral laceration or contusion (851).

(h) History of epidural, subdural, subarachnoid, or intercerebral hematoma (852).

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

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

(k) Focal neurologic signs.

(l) Radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.

(m) Leptomeningeal cysts or Arteriovenous Fistula.

(2) History of moderate head injury (854.03) does not meet the standard. After 2 years post-injury, applicants may be qualified if neurological consultation shows no residual dysfunction or complications. Moderate head injuries are defined as unconsciousness, amnesia, or disorientation of person, place, or time alone or in combination, of more than 1 and less than 24-hours duration post-injury, or linear skull fracture.

(3) History of mild head injury (854.02) does not meet the standard. After 1 month post-injury, applicants may be qualified if neurological evaluation shows no residual dysfunction or complications. Mild head injuries are defined as a period of unconsciousness, amnesia, or disorientation of person, place, or time, alone or in combination of 1 hour or less post-injury.

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

g. Infectious diseases of the central nervous system.

(1) Current or history of acute infectious processes of the central nervous system, including, but not limited to meningitis (322), encephalitis (323), or brain abscess (324), do not meet the standard if occurring within 1 year before examination, or if there are residual neurological defects.

(2) History of neurosyphilis (094) of any form, including but not limited to general paresis, tabes dorsalis or meningovascular syphilis, does not meet the standard.

h. Current or history or narcolepsy or cataplexy (347) does not meet the standard.

i. Current or history of paralysis, weakness, lack of coordination, chronic pain, sensory disturbance, or other specified paralytic syndromes (344) does not meet the standard.

j. Epilepsy (345) occurring beyond the 6thbirthday, 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 electroencephalogram (EEG) does not meet the standard. All such applicants will have a current neurology consultation with current EEG results.

k. Chronic nervous system disorders, including but not limited to myasthenia gravis (358.0), multiple sclerosis (340), and tic disorders (307.20) (for example, Tourett's (307.23)) do not meet the standard.

l. Current or history of retained central nervous system shunts of all kinds (V45.2) do not meet the standard.

2–27. Learning, psychiatric and behavioral disorders

a. Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (314), or Perceptual/Learning Disorder(s) (315) does not meet the standard, unless applicant can demonstrate passing academic performance and there has been no use of medication(s) in the previous 12 months.

b. Current or history of academic skills or perceptual defects (315) secondary to organic or functional mental disorders, including, but not limited to dyslexia, that interfere with school or employment, do not meet the standard. Applicants demonstrating passing academic and employment performance without utilization or recommendation of academic and/or work accommodations at any time in the previous 12 months may be qualified.

c. Current or history of disorders with psychotic features such as schizophrenia (295), paranoid disorder (297), and other unspecified psychosis (298) does not meet the standard.

d. Current mood disorders including, but not limited to, major depression (296.2–3), bipolar (296.4–7), affective psychoses (296.8–9), depressive not otherwise specified (311), do not meet the standard.

(1) History of mood disorders requiring outpatient care for longer than 6 months by a physician or other mental health professional (V65.40), or inpatient treatment in a hospital or residential facility does not meet the standard.

(2) History of symptoms consistent with a mood disorder of a repeated nature that impairs school, social, or work efficiency does not meet the standard.

e. Current or history of adjustment disorders (309) within the previous 3 months does not meet the standard.

f. Current or history of conduct (312), or behavior (313) disorders does not meet the standard. Recurrent encounters with law enforcement agencies, antisocial attitudes or behaviors are tangible evidence of impaired capacity to adapt to military service and as such do not meet the standard.

g. Current or history of personality disorder (301) does not meet the standard. History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups), interview, or psychological testing revealing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency will likely interfere with adjustment in the Armed Forces does not meet the standard.

h. Current or history of other behavior disorders does not meet the standard, including, but not limited to conditions such as the following:

(1) Enuresis (307.6) or encopresis (307.7) after 13th birthday does not meet the standard.

(2) Sleepwalking (307.4) after 13th birthday does not meet the standard.

(3) Eating disorders (307.5), anorexia nervosa (307.1), bulimia (307.51), or unspecified disorders of eating (307.59) lasting longer than 3 months and occurring after 13th birthday do not meet the standard.

i. Any current receptive or expressive language disorder, including, but not limited to any speech impediment, stammering and stuttering (307.0) of such a degree as to significantly interfere with production of speech or to repeat commands, does not meet the standard.

j. History of suicidal behavior, including gesture(s) or attempt(s) (300.9), or history of self-mutilation, does not meet the standard.

k. Current or history of anxiety disorders (anxiety (300.01) or panic (300.2)), agoraphobia (300.21), social phobia (300.23), simple phobias (300.29), obsessive-compulsive (300.3), other acute reactions to stress (308), and post-traumatic stress disorder (309.81) do not meet the standard.

l. Current or history of dissociative disorders, including, but not limited to hysteria (300.1), depersonalization (300.6), and other (300.8), do not meet the standard.

m. Current or history of somatoform disorders, including, but not limited to hypochondriasis (300.7) or chronic pain disorder, do not meet the standard.

n. Current or history of paraphilic disorders (302), including, but not limited to, exhibitionistic disorder, transvestic disorder, voyeuristic disorder, and other paraphilic disorders, do not meet the standard.

o. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305), or other drug abuse (305.2 thru 305.9) does not meet the standard.

p. Current or history of other mental disorders (all 290–319 not listed above) that in the opinion of the civilian or military provider will interfere with, or prevent satisfactory performance of military duty, do not meet the standard.

2–28. Skin and cellular tissues

a. Current diseases of sebaceous glands to include severe acne (706.1), if extensive involvement of the neck, shoulders, chest, or back is present or would be aggravated by or interfere with the proper wearing of military equipment, do not meet the standard. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (Accutane(r)) are disqualified until 8 (eight) weeks after completion of therapy.

b. Current or history of atopic dermatitis (691) or eczema (692) after the 9thbirthday does not meet the standard.

c. Current or history of contact dermatitis (692.4), especially involving materials used in any type of required protective equipment, does not meet the standard.

d. Cysts.

(1) Current cysts (706.2), (other than pilonidal cysts) of such a size or location as to interfere with the proper wearing of military equipment does not meet the standard.

(2) Current pilonidal cysts (685), if evidenced by the presence of a tumor mass or a discharging sinus does not meet the standard. Surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-operative does not meet the standard.

e. Current or history of bullous dermatoses (694), including, but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa, does not meet the standard.

f. Current chronic lymphedema (457.1) does not meet the standard.

g. Current localized types of fungus infections (117), interfering with the proper wearing of military equipment or the performance of military duties, do not meet the standard. (For systemic fungal infections, refer to paragraph 2–30.)

h. Current or history of furunculosis or carbuncle (680), if extensive, recurrent, or chronic does not meet the standard.

i. Current or history of severe hyperhidrosis of hands or feet (780.8) does not meet the standard.

j. Current or history of congenital (757) or acquired (216) anomalies of the skin such as nevi or vascular tumors that interfere with function, or are exposed to constant irritation do not meet the standard. History of Dysplastic Nevus Syndrome (232) does not meet the standard.

k. Current or history of keloid formation (701.4), if the tendency is marked or interferes with the proper wearing of military equipment, does not meet the standard.

l. Current lichen planus (697.0) does not meet the standard.

m. Current or history of neurofibromatosis (von Recklinghausen's disease) (237.7) does not meet the standard.

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

o. Current or history of psoriasis (696.1) does not meet the standard.

p. Current or history of radiodermatitis (692.82) does not meet the standard.

q. Current scars (709.2), or any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, which in the opinion of the certifying authority affects thermoregulatory function, or will interfere

with the wearing of military clothing or equipment, or which exhibits a tendency to ulcerate, or interferes with the satisfactory performance of duty, do not meet the standard. Includes scars at skin graft donor or recipient sites. Scars at skin graft donor or recipient sites will include an evaluation of not only the relative total size of the burn wound, but also the measurable effects of the wound, the location of the wound and the risk of subsequent injury related to the wound itself.

(1) Prior burn injury (to include donor sites) involving a total body surface area of 40 percent or more does not meet the standard.

(2) Prior burn injury involving less than 40 percent total body surface area, which results in a loss or degradation of thermoregulatory function does not meet the standard. Examination will focus on the depth of the burn, anatomic location (extensive burns on the torso will most significantly impair heat dissipation), and destruction of sweat glands.

(3) Prior burn injury susceptible to trauma or resulting in functional impairment to such a degree as to interfere with the satisfactory performance of military duty, due to decreased range of motion, strength, or agility due to burn wound/scarring does not meet the standard.

r. Current or history of extensive scleroderma (710.1) does not meet the standard.

s. Tattoos (709.9) that are otherwise prohibited under AR 670–1 do not meet the standard.

t. Current of history of chronic or recurrent urticaria (708.8) does not meet the standard.

u. Current symptomatic plantar wart(s) (078.19) does not meet the standard.

2–29. Spine and sacroiliac joints

a. Current or history of ankylosing spondylitis or other inflammatory spondylopathies (720) does not meet the standard. (See para 2–11*a*.)

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

(1) Prevent the individual from successfully following a physically active vocation in civilian life (724) or that is associated with local or referred pain to the extremities, muscular spasm, postural deformities, or limitation of motion does not meet the standard.

(2) Require external support does not meet the standard.

(3) Require limitation of physical activity or frequent treatment does not meet the standard.

c. Current deviation or curvature of spine (737) from normal alignment, structure, or function does not meet the standard if:

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

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

(3) It is symptomatic.

(4) There is lumbar scoliosis greater than 20 degrees, thoracic scoliosis greater than 30 degrees, or kyphosis and lordosis greater than 55 degrees when measured by the Cobb method.

d. History of congenital fusion (756.15), involving more than two vertebral bodies does not meet the standard. Any surgical fusion of spinal vertebrae (P81.0) does not meet the standard.

e. Current or history of fractures or dislocation of the vertebrae (805) does not meet the standard. A compression fracture, involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.

f. History of juvenile epiphysitis (732.6) with any degree of residual change indicated by x-ray or kyphosis does not meet the standard.

g. Current herniated nucleus pulposus (722) or history of surgery to correct this condition does not meet the standard.

h. Current or history of spina bifida (741) when symptomatic, if there is more than one vertebra level involved or with dimpling of the overlying skin does not meet the standard. History of surgical repair of spina bifida does not meet the standard.

i. Current or history of spondylolysis (congenital (756.11) or acquired (738.4)) and spondylolisthesis (congenital (756.12) or acquired (738.4)) do not meet the standard.

2–30. Systemic diseases

a. Current or history of disorders involving the immune mechanism including immunodeficiencies (279) does not meet the standard. Presence of Human Immunodeficiency Virus (HIV) or serologic evidence of infection (042) does not meet the standard. Positive Enzyme-Linked Immunoabsorbent Assay test(s) for HIV with ambiguous or inconclusive results on Western Blot testing does not meet the standard.

b. Current or history of lupus erythematosus (710.0) or mixed connective tissue disease variant (710.9) does not meet the standard.

c. Current or history of progressive systemic sclerosis (710.1), including CRST Variant, does not meet the standard. A single plaque of localized Scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.

d. Current or history of Reiter's disease (099.3) does not meet the standard.

e. Current or history of rheumatoid arthritis (714.0) does not meet the standard.

f. Current or history of Sjögren's syndrome (710.2) does not meet the standard.

g. Current or history of vasculitis, including, but not limited to polyarteritis nodosa and allied conditions (446.0), arteritis (447.6), Behçet's (136.1), and Wegner's granulomatosis (446.4), does not meet the standard.

h. Tuberculosis (010)

(1) Current active tuberculosis or substantiated history of active tuberculosis in any form or location, regardless of past treatment, in the previous 2 years, does not meet the standard.

(2) Current residual physical or mental defects from past tuberculosis that will prevent the satisfactory performance of duty do not meet the standard.

(3) Individuals with a past history of active tuberculosis greater than 2 years before appointment, enlistment, or induction are qualified if they have received a complete course of standard chemotherapy for tuberculosis. Individuals with a tuberculin reaction in accordance with the guidelines of the American Thoracic Society and U.S. Public Health Service (ATS/USPHS), and without evidence of residual disease in pulmonary or non-pulmonary sites are eligible for enlistment induction, and appointment, provided they have received chemoprophylaxis in accordance with the guidelines of the ATS/USPHS.

(4) Current or history of untreated latent tuberculosis (positive Purified Protein Derivative with negative chest x-ray) (795.5) does not meet the standard.

i. Current untreated syphilis does not meet the standard (097).

j. History of anaphylaxis (995.0), including, but not limited to idiopathic and exercise-induced; anaphylaxis to venom, including stinging insects (989.5); foods or food additives (995.60–69); or to natural rubber latex (989.82), does not meet the standard.

k. Current residual of tropical fevers, including, but not limited to fevers, such as malaria (084) and various parasitic or protozoan infestations that prevent the satisfactory performance of military duty, does not meet the standard.

l. Current sleep disturbances (780.5), including, but not limited to sleep apneas, does not meet the standard.

m. History of malignant hyperthermia (995.86) does not meet the standard.

n. History of industrial solvent or other chemical intoxication (982) with sequelae does not meet the standard.

o. History of motion sickness (994.6) resulting in recurrent incapacitating symptoms or of such a severity to require pre-medication in the previous 3 years does not meet the standard.

p. History of rheumatic fever (390) does not meet the standard.

q. Current or history of muscular dystrophies (359) or myopathies does not meet the standard.

r. Current or history of amyloidosis (277.3) does not meet the standard.

s. Current or history of eosinophilic granuloma (277.8) does not meet the standard. Healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, will not be a cause for disqualification. All other forms of the Histiocytosis (202.3) do not meet the standard.

t. Current or history of polymyositis (710.4) /dermatomyositis complex (710.3) with skin involvement does not meet the standard.

u. History of rhabdomyolysis (728.88) does not meet the standard.

v. Current or history of sarcoidosis (135) does not meet the standard.

w. Current systemic fungus infections (117) do not meet the standard. For localized fungal infections, refer to paragraph 2–28*g*.

2–31. Tumors and malignant diseases

a. Current benign tumors (M8000), or conditions that interfere with function, prevent the proper wearing of the uniform or protective equipment, or will require frequent specialized attention, or have a high malignant potential, such as Dysplastic Nevus Syndrome, do not meet the standard.

b. Current or history of malignant tumors (V10) does not meet the standard. Skin cancer (other than malignant melanoma) removed with no residual, is not disqualifying.

2–32. General and miscellaneous conditions and defects

a. Current or history of parasitic diseases, if symptomatic or carrier state, including, but not limited to filariasis (125), trypanosomiasis (086), schistosomiasis (120), hookworm (uncinariasis) (126.9), and unspecified infectious and parasitic disease (136.9), do not meet the standard.

b. Current or history of other disorders, including, but not limited to cystic fibrosis (277.0), or porphyria (277.1), that prevent satisfactory performance of duty or require frequent or prolonged treatment do not meet the standard.

c. Current or history of cold-related disorders, including, but not limited to frostbite, chilblain, immersion foot (991), or cold urticaria (708.2), do not meet the standard. Current residual effects of cold-related disorders, including, but not limited to paresthesias, easily traumatized skin, cyanotic amputation of any digit, ankylosis, trench foot, or deep-seated ache, do not meet the standard.

d. History of angioedema, including hereditary angioedema (277.6), does not meet the standard.

e. History of receiving organ or tissue transplantation (V42) does not meet the standard.

f. History of pulmonary (415) or systemic embolization (444) does not meet the standard.

g. History of untreated acute or chronic metallic poisoning, including, but not limited to lead, arsenic, silver (985), beryllium, or manganese (985), does not meet the standard. Current complications or residual symptoms of such poisoning do not meet the standard.

h. History of heat pyrexia (992.0), heatstroke (992.0), or sunstroke (992.0) does not meet the standard. History of three or more episodes of heat exhaustion (992.3) does not meet the standard. Current or history of a predisposition to heat injuries, including disorders of sweat mechanism, combined with a previous serious episode does not meet the standard. Current or history of any unresolved sequelae of heat injury, including, but not limited to nervous, cardiac, hepatic or renal systems, does not meet the standard.

i. Current or history of any condition that in the opinion of the medical officer will significantly interfere with the successful performance of military duty or training does not meet the standard (should use specific ICD code whenever possible, or 796.9).

j. Any current acute pathological condition, including, but not limited to acute communicable diseases, until recovery has occurred without sequelae, does not meet the standard.

Table 2–1
Military acceptable weight (in pounds) as related to age and height for males—initial Army procurement

		Maximum weight by years of age			
Height (inches)	Minimum weight any age yielding a BMI of 19	17–20	21–27	28–39	40 and over
60	97	139	141	143	146
61	100	144	146	148	151
62	104	148	150	153	156
63	107	153	155	158	161
64	110	158	160	163	166
65	114	163	165	168	171
66	117	168	170	173	177
67	121	174	176	179	182
68	125	179	181	184	187
69	128	184	186	189	193
70	132	189	192	195	199
71	136	194	197	201	204
72	140	200	203	206	210
73	144	205	208	212	216
74	148	211	214	218	222
75	152	217	220	224	228
76	156	223	226	230	234
77	160	229	232	236	240
78	164	235	238	242	247
79	168	241	244	248	253
80	173	247	250	255	259
		Maximum body fat by years of age			
		17–20	21–27	28–39	40 and over
		26%	26%	28%	30%

Note:

[1] If a male exceeds these weights, percent body fat will be measured by the method described in AR 600–9.

[2] If a male also exceeds this body fat, he will be rejected for service.

Table 2–2
Military acceptable weight (in pounds) as related to age and height for females—initial Army procurement

		Maximum weight by years of age			
Height (inches)	Minimum weight any age yielding a BMI of 19	17–20	21–27	28–39	40 and over
58	91	122	124	126	127
59	94	127	128	130	131
60	97	132	134	135	136
61	100	136	137	139	141
62	104	140	141	144	145
63	107	145	147	148	149
64	110	149	151	153	154
65	114	154	156	158	160
66	117	160	160	162	165
67	121	163	166	168	169
68	125	168	171	173	174
69	128	173	176	178	180
70	132	178	181	183	185
71	136	183	186	188	191
72	140	189	191	194	196
73	144	194	196	200	202
74	148	199	203	204	206
75	152	205	208	210	212
76	156	210	213	215	216
77	160	216	219	221	223
78	164	222	224	227	229
79	168	227	230	234	236
80	173	233	236	240	241
		Maximum body fat by years of age			
		17–20	21–27	28–39	40 and over
		32%	32%	34%	36%

Note:

[1] If a female exceeds these weights, percent body fat will be measured by the method described in AR 600–9.

[2] If a female also exceeds this body fat, she will be rejected for service.

Chapter 3
Medical Fitness Standards for Retention and Separation, Including Retirement

3–1. General

This chapter gives the various medical conditions and physical defects which may render a Soldier unfit for further military service and which fall below the standards required for the individuals in paragraph 3–2, below. These medical conditions and physical defects, individually or in combination, are those that—

a. Significantly limit or interfere with the Soldier's performance of their duties.

b. May compromise or aggravate the Soldier's health or well-being if they were to remain in the military Service. This may involve dependence on certain medications, appliances, severe dietary restrictions, or frequent special treatments, or a requirement for frequent clinical monitoring.

c. May compromise the health or well-being of other Soldiers.

d. May prejudice the best interests of the Government if the individual were to remain in the military Service.

3–2. Application

These standards apply to the following individuals (see chaps 4 and 5 for other standards that apply to specific specialties):

a. All commissioned and warrant officers of the Active Army, ARNG/ARNGUS, and USAR.

b. All enlisted Soldiers of the Active Army, ARNG/ARNGUS, and USAR.

c. Students already enrolled in the HPSP and USUHS programs.

d. Enlisted Soldiers of the ARNG/ARNGUS or USAR who apply for enlistment in the Active Army.

e. Commissioned and warrant officers of the ARNG/ARNGUS or USAR who apply for appointment in the Active Army.

f. Soldiers of the ARNG/ARNGUS or USAR who re-enter active duty under the "split-training option." (However, the weight standards of tables 2–1 and 2–2 apply to split option trainees.)

g. Retired Soldiers recalled to active duty.

3–3. Disposition

Soldiers with conditions listed in this chapter who do not meet the required medical standards will be evaluated by an MEB as defined in AR 40–400 and will be referred to a PEB as defined in AR 635–40 with the following caveats:

a. USAR or ARNG/ARNGUS Soldiers not on active duty, whose medical condition was not incurred or aggravated during an active duty period, will be processed in accordance with chapter 9 and chapter 10 of this regulation.

b. Soldiers pending separation in accordance with provisions of AR 635–200 or AR 600–8–24 authorizing separation under other than honorable conditions who do not meet medical retention standards will be referred to an MEB. In the case of enlisted Soldiers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 635–200 and AR 635–40. In the case of commissioned or warrant officers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 600–8–24 and AR 635–40.

c. A Soldier will not be referred to an MEB or a PEB because of impairments that were known to exist at the time of acceptance in the Army and that have remained essentially the same in degree of severity and have not interfered with successful performance of duty.

d. Physicians who identify Soldiers with medical conditions listed in this chapter should initiate an MEB at the time of identification. Physicians should not defer initiating the MEB until the Soldier is being processed for nondisability retirement. Many of the conditions listed in this chapter (for example, arthritis in para 3–14*b)* fall below retention standards only if the condition has precluded or prevented successful performance of duty. In those cases when it is clear the condition is long standing and has not prevented the Soldier from reaching retirement, then the Soldier meets the standard and an MEB is not required.

e. Soldiers who have previously been found unfit for duty by a PEB, but were continued on active duty (COAD) under the provisions of AR 635–40, chapter 6, will be referred to a PEB prior to retirement or separation processing.

f. If the Secretary of Defense prescribes less stringent standards during partial or full mobilization, individuals who meet the less stringent standards but do not meet the standards of this chapter will not be referred for an MEB or a PEB, until the termination of the mobilization or as directed by the Secretary of the Army.

3–4. General policy

Possession of one or more of the conditions listed in this chapter does not mean automatic retirement or separation from the Service. Physicians are responsible for referring Soldiers with conditions listed below to an MEB. It is critical that MEBs are complete and reflect all of the Soldier's medical problems and physical limitations. The PEB will make the determination of fitness or unfitness. The PEB, under the authority of the U.S. Army Physical Disability Agency, will consider the results of the MEB, as well as the requirements of the Soldier's MOS, in determining fitness. (See chapter 9 and chapter 10 of this regulation for processing of RC Soldiers.)

3–5. Abdominal and gastrointestinal defects and diseases

The causes for referral to an MEB are as follows:

a. Achalasia (cardiospasm) with dysphagia not controlled by dilatation or surgery, continuous discomfort, or inability to maintain weight.

b. Amoebic abscess with persistent abnormal liver function tests and failure to maintain weight and vigor after appropriate treatment.

c. Biliary dyskinesia with frequent abdominal pain not relieved by simple medication, or with periodic jaundice.

d. Cirrhosis of the liver with recurrent jaundice, ascites, or demonstrable esophageal varices or history of bleeding therefrom.

e. Gastritis, if severe, chronic hypertrophic gastritis with repeated symptomatology and hospitalization, confirmed by gastroscopic examination.

f. Hepatitis, B or C, chronic, when following the acute stage, symptoms persist, and there is objective evidence of impairment of liver function. Chronic hepatitis B as documented by positive hepatitis B surface or e antigen or detectable hepatitis B Deoxyribonucleic acid (DNA) viral load in serum. Chronic hepatitis C as documented by detectable hepatitis C RNA viral load in serum.

g. Hernia, including inguinal, and other abdominal, except for small asymptomatic umbilical, with severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment or other hernias if symptomatic and if operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

h. Crohn's Disease/Ileitis, regional, except when responding well to treatment.

i. Pancreatitis, chronic, with frequent abdominal pain of a severe nature; steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.

j. Peritoneal adhesions with recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent admissions to the hospital.

k. Proctitis, chronic, with moderate to severe symptoms of bleeding, painful defecation, tenesmus, and diarrhea, and repeated admissions to the hospital.

l. Ulcer, duodenal, or gastric with repeated hospitalization, or "sick in quarters" because of frequent recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management and supported by endoscopic evidence of activity.

m. Ulcerative colitis, except when responding well to treatment.

n. Rectum, stricture of with severe symptoms of obstruction characterized by intractable constipation, pain on defecation, or difficult bowel movements, requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

3–6. Gastrointestinal and abdominal surgery

The causes for referral to an MEB are as follows:

a. Colectomy, partial or total, when more than mild symptoms of diarrhea remain or if complicated by colostomy.

b. Colostomy, when permanent.

c. Enterostomy, when permanent.

d. Gastrectomy, total.

e. Gastrectomy, subtotal, with or without vagotomy, or gastrojejunostomy, with or without vagotomy, when, in spite of good medical management, the individual develops "dumping syndrome" which persists for 6 months postoperatively; or develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively; or continues to demonstrate appreciable weight loss 6 months postoperatively.

f. Gastrostomy, when permanent.

g. Ileostomy, when permanent.

h. Pancreatectomy.

i. Pancreaticoduodenostomy, pancreaticogastrostomy, or pancreaticojejunostomy, followed by more than mild symptoms of digestive disturbance, or requiring insulin.

j. Proctectomy.

k. Proctopexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after an appropriate treatment period.

3–7. Blood and blood-forming tissue diseases

The causes for referral to an MEB are as follows:

a. Anemia, hereditary, acquired, aplastic, or unspecified, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

b. Hemolytic crisis, chronic and symptomatic.

c. Leukopenia, chronic, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

d. Hypogammaglobulinemia with objective evidence of function deficiency and severe symptoms not controlled with treatment.

e. Purpura and other bleeding diseases, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

f. Thromboembolic disease when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

g. Splenomegaly, chronic.

h. HIV confirmed antibody positivity, with the presence of progressive clinical illness or immunological deficiency. For Active Army Soldiers and RC Soldiers on active duty for more than 30 days (except for training under 10 USC 10148), an MEB must be accomplished and, if appropriate, the Soldier must be referred to a PEB under AR 635–40. For RC Soldiers not on active duty for more than 30 days or on ADT under 10 USC 10148, referral to a PEB will be determined under AR 635–40. Records of official diagnoses provided by private physicians (that is, civilian doctors providing evalu-

ations under contract with Department of the Army (DA) or DOD, or civilian public health officials) concerning the presence of progressive clinical illness or immunological deficiency in RC Soldiers may be used as a basis for administrative action under, for example, AR 135–133, AR 135–175, AR 135–178, or AR 140–10, as appropriate. (See AR 600–110 for HIV policies, including testing requirements.)

3–8. Dental diseases and abnormalities of the jaws

The causes for referral to an MEB are diseases of the jaws, periodontium, or associated tissues when, following restorative surgery, there are residuals that are incapacitating or interfere with the individual's satisfactory performance of military duty.

3–9. Ears

The causes for referral to an MEB are as follows:

a. Infections of the external auditory canal when chronic and severe, resulting in thickening and excoriation of the canal or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.

b. Malfunction of the acoustic nerve. (Evaluate functional impairment of hearing under para 3–10.)

c. Mastoiditis, chronic, with constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.

d. Mastoiditis, chronic, following mastoidectomy, with constant drainage from the mastoid cavity, requiring frequent and prolonged medical care or hospitalization.

e. Ménière's syndrome or any peripheral imbalance, syndrome or labyrinthine disorder with recurrent attacks of sufficient frequency and severity as to interfere with the satisfactory performance of duty or requiring frequent or prolonged medical care or hospitalization.

f. Otitis media, moderate, chronic, suppurative, resistant to treatment, and necessitating frequent and prolonged medical care or hospitalization.

3–10. Hearing

The causes for referral to an MEB are as follows:

a. Soldiers incapable of performing their military duties with a hearing aid (see para 8–27).

b. Soldiers who fail the Speech Recognition In Noise Test (SPRINT).

c. Soldiers with a permanent H4 hearing profile.

3–11. Endocrine and metabolic disorders

The causes for referral to an MEB are as follows:

a. Acromegaly.

b. Adrenal insufficiency requiring replacement therapy.

c. Diabetes insipidus requiring the use of medication for control.

d. Diabetes mellitus, unless hemoglobin A1c can be maintained at <(less than) 7% using only lifestyle modifications (diet, exercise).

e. Goiter causing breathing obstruction.

f. Gout in advanced cases with frequent acute exacerbations and severe bone, joint, or kidney damage.

g. Fasting hypoglycemia (as documented during a 72-hour fast) when caused by an insulinoma or other hypoglycemia-inducing tumor.

h. Hyperparathyroidism when residuals or complications of surgical correction such as renal disease or bony deformities preclude the reasonable performance of military duty.

i. Cushing's syndrome.

j. Osteomalacia or osteoporosis resulting in fracture with residuals after therapy of such nature or degree as to preclude the satisfactory performance of duty.

k. Primary hyperaldosteronism when resulting in uncontrolled hypertension and/or hypokalemia.

l. Multiple endocrine neoplasia, any type.

m. Pituitary macroadenomas when resulting in hypothalamic/pituitary dysfunction or symptoms of mass effect.

n. Pheochromocytoma.

o. Thyroid carcinoma, any type, if persistent despite usual therapy (surgery, radioactive iodine and treatment with suppressive doses of levothyroxine).

p. Hypoparathyroidism, when severe, persistent, and difficult to manage.

q. Salt-wasting congenital adrenal hyperplasia.

r. Carcinoid syndrome.

s. Endocrine tumors of the gastrointestinal tract, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision. Such tumors include gastrinoma, glucagonoma, vipoma, neurotensinoma, PPoma, and somatostatinoma.

3–12. Upper extremities

The causes for referral to an MEB are as follows (see also para 3–14):

a. Amputation.

(1) For purposes of this regulation, upper extremity amputation is defined as the loss of part or parts of an upper extremity equal to or greater than--

(a) A thumb proximal to the interphalangeal joint.

(b) Two fingers of one hand, other than the little finger, at the proximal interphalangeal joints.

(c) One finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.

(2) Soldiers with amputations will (assuming no other disqualifying medical conditions) be provided a temporary profile not less than 4 months (but not to exceed 1 year) to enable the Soldier to attain maximum medical benefit.

b. Joint ranges of motion (ROM) which do not equal or exceed the measurements listed below. Measurements should be made with a goniometer (a bubble goniometer/inclinometer is also acceptable) and conform to the methods illustrated and described in the Veterans Administration Schedule for Rating Disabilities (VASRD). SF Form 527 (Medical Record—Group Muscle Strength, Joint R.O.M. Girth and Length Measurements) should be used to document the ROM and the method of measurement.

(1) Shoulder—forward elevation to 90 degrees, or abduction to 90 degrees.

(2) Elbow—flexion to 100 degrees, or extension to 60 degrees.

(3) Wrist—a total range extension plus flexion of 15 degrees.

(4) Hand (for this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints (VASRD))—an active flexor value of combined joint motions of 135 degrees in each of two or more fingers of the same hand, or an active extensor value of combined joint motions of 75 degrees in each of the same two or more fingers, or limitation of motion of the thumb that precludes opposition to at least two finger tips.

c. Recurrent dislocations of the shoulder, when not repairable or surgery is contradicated.

3–13. Lower extremities

The causes for referral to an MEB are as follows (see also para 3–14):

a. Amputations.

(1) Lower extremity amputations are defined, for purposes of this regulation, as follows:

(a) Loss of toes that precludes the abilities to run or walk without a perceptible limp and to engage in fairly strenuous jobs.

(b) Any loss greater than that specified above to include foot, ankle, below the knee, above the knee, femur, hip.

(2) Soldiers with amputations will (assuming no other disqualifying medical conditions) be provided a temporary profile not less than 4 months (but not to exceed 1 year) to enable the Soldier to attain maximum medical benefit.

b. Feet.

(1) Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(2) Pes planus, when symptomatic, more than moderate, with pronation on weight bearing which prevents the wearing of military footwear, or when associated with vascular changes.

(3) Pes cavus when moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, and which prevents the wearing of military footwear.

(4) Neuroma that is refractory to medical treatment, refractory to surgical treatment, and interferes with the satisfactory performance of military duties.

(5) Plantar fascitis or heel spur syndrome that is refractory to medical or surgical treatment, interferes with the satisfactory performance of military duties, or prevents the wearing of military footwear.

(6) Hammertoes, severe, that precludes the wearing of appropriate military footwear, refractory to surgery, or interferes with satisfactory performance of duty.

(7) Hallux limitus, hallux rigidus.

c. Internal derangement of the knee.

(1) Residual instability following remedial measures, if more than moderate in degree.

(2) If complicated by arthritis, see paragraph 3–14*a*.

d. *Joint ranges of motion (ROM).* ROM that does not equal or exceed the measurements listed below. Measurements should be made with a goniometer (a bubble goniometer/inclinometer is also acceptable) and conform to the methods illustrated and described in the VASRD.

(1) Hip—flexion to 90 degrees or extension to 0 degree.

(2) Knee—flexion to 90 degrees or extension to 15 degrees.

(3) Ankle—dorsiflexion to 10 degrees or planter flexion to 10 degrees.

e. Shortening of an extremity that exceeds 2 inches.

f. Recurrent dislocations of the patella. (See also para 3–14.)

3–14. Miscellaneous conditions of the extremities

The causes for referral to an MEB are as follows (see also paras 3–12 and 3–13):

a. Arthritis due to infection, associated with persistent pain and marked loss of function with objective x-ray evidence and documented history of recurrent incapacity for prolonged periods. For arthritis due to gonococcic or tuberculous infection, see paragraphs 3–40*j* and 3–45*b*.

b. Arthritis due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joints so as to preclude the satisfactory performance of duty.

c. Osteoarthritis, with severe symptoms associated with impairment of function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.

d. Avascular necrosis of bone when severe enough to prevent successful performance of duty.

e. Chondromalacia or osteochondritis dissecans, severe, manifested by frequent joint effusion, more than moderate interference with function, or with severe residuals from surgery.

f. Fractures.

(1) Malunion of fractures, when, after appropriate treatment, there is more than moderate malunion with marked deformity and more than moderate loss of function.

(2) Nonunion of fractures, when, after an appropriate healing period, the nonunion precludes satisfactory performance of duty.

(3) Bone fusion defect, when manifested by more than moderate pain and loss of function.

(4) Callus, excessive, following fracture, when functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

g. Joints.

(1) Arthroplasty with severe pain, limitation of motion, and of function.

(2) Bony or fibrous ankylosis, with severe pain involving major joints or spinal segments in an unfavorable position, and with marked loss of function.

(3) Contracture of joint, with marked loss of function and the condition is not remediable by surgery.

(4) Loose bodies within a joint, with marked functional impairment and complicated by arthritis to such a degree as to preclude favorable results of treatment or not remediable by surgery.

(5) Prosthetic replacement of major joints if there is resultant loss of function or pain that precludes satisfactory performance of duty.

h. Muscles.

(1) Flaccid paralysis of one or more muscles with loss of function that precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.

(2) Spastic paralysis of one or more muscles with loss of function that precludes the satisfactory performance of military duty.

i. Myotonia congenita.

j. Osteitis deformans (Paget's disease) with involvement of single or multiple bones with resultant deformities or symptoms severely interfering with function.

k. Osteoarthropathy, hypertrophic, secondary with moderately severe to severe pain present, with joint effusion occurring intermittently in one or multiple joints, and with at least moderate loss of function.

l. Osteomyelitis, chronic, with recurrent episodes not responsive to treatment and involving the bone to a degree that interferes with stability and function.

m. Tendon transplant with fair or poor restoration of function with weakness that seriously interferes with the function of the affected part. (See also paras 3–12 and 3–13.)

n. Tendinopathy. Any tendonitis, tenosynovitis, or tendinopathy that precludes satisfactory performance of military duties.

3–15. Eyes

The causes for referral to an MEB are as follows:

a. Active eye disease or any progressive organic disease or degeneration, regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual fields so that distant visual acuity does not meet the standard stated in paragraph 3–16*e* or the diameter of the field of vision in the better eye is less than 20 degrees.

b. Aphakia, bilateral.

c. Atrophy of the optic nerve due to disease.

d. Glaucoma, if resistant to treatment or affecting visual fields as in a above, or if side effects of required medication are functionally incapacitating.

e. Degenerations, when vision does not meet the standards of paragraph 3–16*e*, or when vision is correctable only by the use of contact lenses or other special corrective devices (telescopic lenses, etc.).

f. Diseases and infections of the eye, when chronic, more than mildly symptomatic, progressive, and resistant to treatment after a reasonable period. This includes intractable allergic conjunctivitis inadequately controlled by medications and immunotherapy.

g. Residuals or complications of injury or disease, when progressive or when reduced visual acuity does not meet the criteria stated in paragraph 3–16*e*.

h. Unilateral detachment of retina if any of the following exists:

(1) Visual acuity does not meet the standard stated in paragraph 3–16*e*.

(2) The visual field in the better eye is constricted to less than 20 degrees.

(3) Uncorrectable diplopia exists.

(4) Detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

i. Bilateral detachment of retina, regardless of etiology or results of corrective surgery.

3–16. Vision

The causes for referral to an MEB are as follows:

a. Aniseikonia, with subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonica lenses.

b. Binocular diplopia, not correctable by surgery, that is severe, constant, and in a zone less than 20 degrees from the primary position.

c. Hemianopsia, of any type if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not considered to fall below required standards.

d. Night blindness, of such a degree that the Soldier requires assistance in any travel at night.

e. Visual acuity.

(1) Vision that cannot be corrected with ordinary spectacle lenses (contact lenses or other special corrective devices (telescopic lenses, and so forth) are unacceptable) to at least: 20/40 in one eye and 20/100 in the other eye, or 20/30 in one eye and 20/200 in the other eye, or 20/20 in one eye and 20/800 in the other eye, or

(2) An eye has been enucleated.

f. Visual field with bilateral concentric constriction to less than 20 degrees.

3–17. Genitourinary system

The causes for referral to an MEB are as follows:

a. Cystitis, when complications or residuals of treatment themselves preclude satisfactory performance of duty.

b. Dysmenorrhea, when symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than 1 day.

c. Endometriosis, symptomatic and incapacitating to a degree that necessitates recurrent absences of more than 1 day.

d. Hypospadias, when accompanied by evidence of chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings and the condition is not amenable to treatment.

e. Incontinence of urine, due to disease or defect not amenable to treatment and of such severity as to necessitate recurrent absence from duty.

f. Kidney.

(1) Calculus in kidney, when bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(2) Congenital anomaly, when bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(3) Cystic kidney (polycystic kidney), when symptomatic and renal function is impaired or is the focus of frequent infection.

(4) Glomerulonephritis, when chronic.

(5) Hydronephrosis, when more than mild, bilateral, and causing continuous or frequent symptoms.

(6) Hypoplasia of the kidney, when symptomatic and associated with elevated blood pressure or frequent infections and not controlled by surgery.

(7) Nephritis, when chronic.

(8) Nephrosis.

(9) Perirenal abscess, with residuals of a degree that precludes the satisfactory performance of duty.

(10) Pyelonephritis or pyelitis, when chronic, that has not responded to medical or surgical treatment, with evidence of hypertension, eye–ground changes, cardiac abnormalities.

(11) Pyonephrosis, when not responding to treatment.

g. Menopausal syndrome, physiologic or artificial, when symptoms are not amenable to treatment and preclude successful performance of duty.

h. Chronic pelvic pain with or without demonstrative pathology that has not responded to medical or surgical treatment and of such severity to necessitate recurrent absence from duty.

i. Strictures of the urethra or ureter, when severe and not amenable to treatment.

j. Urethritis, chronic, when not responsive to treatment and necessitating frequent absences from duty.

3–18. Genitourinary and gynecological surgery

The causes for referral to an MEB are as follows:

a. Cystectomy.

b. Cystoplasty, if reconstruction is unsatisfactory or if residual urine persists in excess of 50 cubic centimeters or if refractory symptomatic infection persists.

c. Hysterectomy, when residual symptoms or complications preclude the satisfactory performance of duty.

d. Nephrectomy, when after treatment, there is infection or pathology in the remaining kidney.

e. Nephrostomy, if drainage persists.

f. Oophorectomy, when complications or residual symptoms are not amenable to treatment and preclude successful performance of duty.

g. Pyelostomy, if drainage persists.

h. Ureterocolostomy.

i. Ureterocystostomy, when both ureters are markedly dilated with irreversible changes.

j. Ureteroileostomy cutaneous.

k. Ureteroplasty.

(1) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider it on the basis of the standard for a nephrectomy; or

(2) When bilateral, evaluate residual obstruction or hydronephrosis and consider it on the basis of the residuals involved.

l. Ureterosigmoidostomy.

m. Ureterostomy, external or cutaneous.

n. Urethrostomy, if there is complete amputation of the penis or when a satisfactory urethra cannot be restored.

o. Kidney transplant recipient. If found fit for duty by a PEB, Soldiers should be restricted to assignment locations where adequate medical care is available and should not deploy to an austere environment. Such Soldiers should not wear individual chemical equipment due to possible drug interactions.

3–19. Head

A skull defect that poses a danger to the Soldier or interferes with the wearing of protective headgear is cause for referral to an MEB.

3–20. Neck

The causes for referral to an MEB are torticollis (wry neck); severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility. (See also paras 3–11 and 3–39*h*.)

3–21. Heart

The causes for referral to an MEB are as follows (see table 3–1 for functional classifications and for metabolic equivalents (METS) ratings to be included in the MEB):

a. Coronary heart disease associated with—

(1) Myocardial infarction, angina pectoris, or congestive heart failure due to fixed obstructive coronary artery disease or coronary artery spasm. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The trial of duty will be for 120 days.

(2) Myocardial infarction with normal coronary artery anatomy. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The trial of duty will be for 120 days.

(3) Angina pectoris in association with objective evidence of myocardial ischemia in the presence of normal coronary artery anatomy.

(4) Fixed obstructive coronary artery disease, asymptomatic but with objective evidence of myocardial ischemia. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The trial of duty will be for 120 days.

b. Supraventricular tachyarrhythmias, when life threatening or symptomatic enough to interfere with performance of duty and when not adequately controlled. This includes atrial fibrillation, atrial flutter, paroxysmal supraventricular tachycardia, and others.

c. Endocarditis with any residual abnormality or if associated with valvular, congenital, or hypertrophic myocardial disease.

d. Heart block (second degree or third degree AV block) and symptomatic bradyarrhythmias, even in the absence of organic heart disease or syncope. Wenckebach second degree heart block occurring in healthy asymptomatic individuals without evidence of organic heart disease is not a cause for referral to a PEB. None of these conditions is cause for MEB/PEB when associated with recognizable temporary precipitating conditions: for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, acute illness.

e. Myocardial disease, New York Heart Association or Canadian Cardiovascular Society Functional Class II or worse. (See table 3–1.)

f. Ventricular flutter and fibrillation, ventricular tachycardia when potentially life threatening (for example, when associated with forms of heart disease that are recognized to predispose to increased risk of death and when there is no definitive therapy available to reduce this risk) or when symptomatic enough to interfere with the performance of duty. None of these ventricular arrhythmias are a cause for medical board referral to a PEB when associated with recognizable temporary precipitating conditions: for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, or acute illness.

g. Sudden cardiac death, when an individual survives sudden cardiac death that is not associated with a temporary or treatable cause, and when there is no definitive therapy available to reduce the risk of recurrent sudden cardiac death.

h. Hypertrophic cardiomyopathy when it restricts activity.

i. Pericarditis as follows:

(1) Chronic constrictive pericarditis unless successful remedial surgery has been performed.

(2) Chronic serous pericarditis.

j. Valvular heart disease with cardiac insufficiency at functional capacity of Class II or worse as defined by the New York Heart Association. (See table 3–1.)

k. Ventricular premature contractions with frequent or continuous attacks, whether or not associated with organic heart disease, accompanied by discomfort or fear of such a degree as to interfere with the satisfactory performance of duty.

l. Recurrent syncope or near syncope of cardiovascular etiology that is not controlled or when it interferes with the performance of duty, even if the etiology is unknown.

m. Any cardiovascular disorder requiring chronic drug therapy in order to prevent the occurrence of potentially fatal or severely symptomatic events that would interfere with duty performance.

n. Congenital heart disease that has long term risks, complications, or impact on duty performance. The exception would be those congenital heart disease conditions that can be repaired with resolution of long term risks, complications, and impact on duty performance.

3–22. Vascular system

The causes for referral to an MEB are as follows:

a. Arteriosclerosis obliterans when any of the following pertain:

(1) Intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest.

(2) Objective evidence of arterial disease with symptoms of claudication, ischemic rest pain, or with gangrenous or ulcerative skin changes of a permanent degree in the distal extremity.

(3) Involvement of more than one organ, system, or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency.

b. Major cardiovascular anomalies including coarctation of the aorta, unless satisfactorily treated by surgical correction or other newly developed techniques, and without any residual abnormalities or complications.

c. Aneurysm of any vessel not correctable by surgery and aneurysm corrected by surgery after a period of up to 90 days trial of duty that results in the individual's inability to perform satisfactory duty. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.

d. Periarteritis nodosa with definite evidence of functional impairment.

e. Chronic venous insufficiency (postphlebitic syndrome) when more than mild and symptomatic despite elastic support.

f. Raynaud's phenomenon manifested by trophic changes of the involved parts characterized by scarring of the skin or ulceration.

g. Thromboangiitis obliterans with intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without rest, or other complications.

h. Thrombophlebitis when repeated attacks requiring treatment are of such frequency as to interfere with the satisfactory performance of duty.

i. Varicose veins that are severe and symptomatic despite therapy.

j. Cold injury. (See paragraph 3–46).

3–23. Miscellaneous cardiovascular conditions

The causes for referral to an MEB are as follows:

a. Hypertensive cardiovascular disease and hypertensive vascular disease. Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status.

b. Rheumatic fever, active, with heart damage. Recurrent attacks.

3–24. Surgery and other invasive procedures involving the heart, pericardium, or vascular system

These procedures include newly developed techniques or prostheses not otherwise covered in this paragraph. The causes for referral to an MEB are as follows:

a. Permanent prosthetic valve implantation.

b. Implantation of permanent pacemakers, antitachycardia and defibrillator devices, and similar newly developed devices.

c. Reconstructive cardiovascular surgery employing exogenous grafting material.

d. Vascular reconstruction, after a period of 90 days trial of duty when medically advisable, that results in the individual's inability to perform satisfactory duty. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.

e. Coronary artery revascularization, with the option of a 120-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as exercise testing and newly developed techniques) indicates that it is medically advisable. Any individual undergoing median sternotomy for surgery will be restricted from lifting 25 pounds or more, performing pullups and pushups, or as otherwise prescribed by a physician for a period of 90 days from the date of surgery on DA Form 3349 (Physical Profile). The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.

f. Heart or heart-lung transplantation.

g. Coronary or valvular angioplasty procedures, with the option of a 180-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as cardiac catheterization, exercise testing, and newly developed techniques) indicates that it is medically advisable. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.

h. Cardiac arrhythmia ablation procedures, with the option of a 180-day trial of duty based upon physician recommendation when asymptomatic, and no evidence of any unfitting arrhythmia as noted in paragraph 3–21. The policies for trial of duty, MEB, and physical profile (as outlined in para 3–25) apply.

i. Congenital heart disease with surgical or percutaneous repair procedures, with the option of a 180-day trial of duty based upon physician recommendations when the individual is asymptomatic and when other functional assessment procedures indicate it is advisable. The policies for trial of duty and referral to an MEB are outlined in paragraph 3–25.

3–25. Trial of duty and profiling for cardiovascular conditions

a. Trial of duty will be based upon a cardiologist’s recommendation when the individual is asymptomatic without objective evidence of myocardial ischemia, and when other functional assessments (such as coronary angiography, exercise testing, and newly developed techniques) indicate it is medically advisable.

b. Prior to commencing the trial of duty period, an evaluation will be accomplished in all cases and a physical activity prescription on DA Form 3349 will be provided by the cardiologist. The results of the trial of duty will include the individual's interim history, present condition, prognosis, and the final recommendations. If the Soldier successfully completes the trial of duty, is considered a New York Heart Association Functional Class I, AND there are no physical or assignment restrictions, the Soldier may be returned to duty without referral to a MEB. If the Soldier has any physical restrictions after the trial of duty; he/she should be referred to an MEB. In addition to the documented results of the trial of duty, a detailed report from the commander or supervisor clearly describing the individual's ability to accomplish assigned duties and to perform physical activity will be incorporated into the MEB record. The results of the MEB and an updated DA Form 3349 will then be forwarded to a PEB if the Soldier does not met medical retention standards. For RC Soldiers not on active duty, the trial of duty may consider performance in the Soldier's civilian position, as well as any military duty that may have been performed in the interim.

c. The following profile guidelines supplement chapter 7. Individuals recommended for a trial of duty will be given a temporary P–3 profile with specific written limitations and instructions for physical and cardiovascular rehabilitation on DA Form 3349. If the Soldier later is referred to a MEB, the completed MEB will include a permanent numerical designator in the "P" factor of the physical profile that is based on functional assessment as follows:

(1) Numerical designator "1." Individuals who are asymptomatic, without objective evidence of myocardial ischemia or other cardiovascular functional abnormality (New York Heart Association Functional Class I).

(2) Numerical designator "2." Individuals with minor physical activity limitations or who require frequent medical follow–up.

(3) Numerical Designator "3." Individuals who are asymptomatic but with objective evidence of myocardial ischemia or other cardiovascular functional abnormality. Those requiring assignment limitations.

(4) Numerical designator "4." Individuals who are symptomatic (New York Heart Association Functional Class II or worse).

3–26. Tuberculosis, pulmonary

The causes for referral to an MEB for pulmonary tuberculosis:

a. If an expiration of service will occur before completion of the period of hospitalization. (Career Soldiers who express a desire to reenlist after treatment may extend their enlistment to cover the period of hospitalization.)

b. When a member of the USAR or ARNG/ARNGUS not on active duty has active disease that will probably require treatment for more than 12 to 15 months including an appropriate period of convalescence before he or she can perform full-time military duty. Individuals who are retained in the USAR or ARNG/ARNGUS while undergoing treatment may not be called or ordered to active duty (including mobilization), ADT, or inactive duty training (IDT) during the period of treatment and convalescence.

3–27. Miscellaneous respiratory disorders

The causes for referral to an MEB are as follows:

a. *Asthma.* This includes reactive airway disease, exercise-induced bronchospasm, asthmatic bronchospasm, or asthmatic bronchitis within the criteria outlined in paragraphs (1) through (4), below.

(1) Definitions/diagnostic criteria are as follows.

(a) Asthma is a clinical syndrome characterized by cough, wheeze, or dyspnea and physiologic evidence of reversible airflow obstruction or airway hyperactivity that persists over a prolonged period of time (generally more than 6 to 12 months).

(b) Reversible airflow obstruction is defined as more than 12 percent increase in forced expiratory volume in 1 second (FEVI) following the administration of an inhaled bronchodilator or prolonged corticosteroid therapy.

(c) Increased bronchial responsiveness is the presence of an exaggerated decrease in airflow induced by a standard bronchoprovocation challenge such as methacholine inhalation (PD20 FEV1 less than or equal to 4mg/ml). Demonstration of exercise induced bronchospasm (12 percent decline in FEV1) is also diagnostic of increased bronchial responsiveness; however, failure to induce bronchospasm with exercise does not rule out the diagnosis of asthma. Bronchoprovocation or exercise testing should be performed by a credentialed provider privileged to perform the procedures.

(d) Soldiers who are diagnosed as having asthma may be placed on a temporary profile under the "P" factor of the physical profile for up to 12 months trial of duty, when medically advisable. If at the end of that period, the Soldier is unable to perform all military training and duty as cited below, the Soldier will be referred to MEB.

(e) Acute, self limited, reversible airflow obstruction and airway hyperactivity can be caused by upper respiratory infections and inhalation of irritant gases or pollutants. This should not be permanently diagnosed as asthma unless significant symptoms or airflow abnormalities persist for more than 12 months.

(2) Chronic asthma is cause for a permanent P–3 or P–4 profile and MEB referral if it—

(a) Results in repetitive hospitalizations, repetitive emergency room visits or excessive time lost from duty.

(b) Requires repetitive use of oral corticosteroids to enable the Soldier to perform all military training and duties.

(c) Results in inability to run outdoors at a pace that meets the standards for the timed 2-mile run despite medications. (The P–3 for the inability to perform the run refers to the inability due to asthma and should not be confused with giving an L2 or L3 based on an underlying orthopedic condition that requires an alternate Army Physical Fitness Test (APFT).)

(d) Prevents the Soldier from wearing a protective mask.

(3) All Soldiers meeting an MEB for asthma should receive a consultation from an internist, pulmonologist, or allergist.

(4) Chronic asthma meets retention standards, but is a cause for a permanent P–2 profile if it—

(a) Requires regular medications including low dose inhaled corticosteroids and/or oral or inhaled bronchodilators; but

(b) Does not prevent the Soldier from otherwise performing all military training and duties including the 2 mile run within time standards.

(5) Soldiers with a diagnosis of asthma who require no medications or activity limitations require no profiling action.

b. *Atelectasis, or massive collapse of the lung.* Moderately symptomatic with paroxysmal cough at frequent intervals throughout the day or with moderate emphysema or with residuals or complications that require repeated hospitalization.

c. *Bronchiectasis or bronchiolectasis.* Cylindrical or saccular type that is moderately symptomatic, with paroxysmal cough at frequent intervals throughout the day or with moderate emphysema with a moderate amount of bronchiectatic sputum or with recurrent pneumonia or with residuals or complications that require repeated hospitalization.

d. *Bronchitis.* Chronic, severe, persistent cough, with considerable expectoration or with dyspnea at rest or on slight exertion or with residuals or complications that require repeated hospitalization.

e. Cystic disease of the lung, congenital disease involving more than one lobe of a lung.

f. Diaphragm, congenital defect. Symptomatic.

g. *Hemopneumothorax, hemothorax, or pyopneumothorax.* More than moderate pleuritic residuals with persistent underweight or marked restriction of respiratory excursions and chest deformity or marked weakness and fatigue on slight exertion.

h. *Histoplasmosis.* Chronic and not responding to treatment.

i. Pleurisy, chronic, or pleural adhesions. Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function.

j. *Pneumothorax, spontaneous.* Recurrent episodes of pneumothorax not corrected by surgery or pleural sclerosis.

k. *Pneumoconiosis.* Severe, with dyspnea on mild exertion.

l. *Pulmonary calcification.* Multiple calcifications associated with significant respiratory embarrassment or active disease not responsive to treatment.

m. *Pulmonary emphysema.* Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

n. *Pulmonary fibrosis.* Linear fibrosis or fibrocalcific residuals of such a degree as to cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

o. *Pulmonary sarcoidosis.* If not responding to therapy and complicated by demonstrable moderate reduction in pulmonary function.

p. *Stenosis, bronchus.* Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring hospitalization of such frequency as to interfere with the satisfactory performance of duty.

3–28. Surgery of the lungs

The cause for referral to an MEB is a complete lobectomy, if pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

3–29. Mouth, esophagus, nose, pharynx, larynx, and trachea

The causes for referral to an MEB are as follows:

a. Esophagus.

(1) Achalasia, unless controlled by medical therapy.

(2) Esophagitis, persistent and severe.

(3) Diverticulum of the esophagus of such a degree as to cause frequent regurgitation, obstruction, and weight loss that does not respond to treatment.

(4) Stricture of the esophagus of such a degree as to almost restrict diet to liquids, require frequent dilatation and hospitalization, and cause difficulty in maintaining weight and nutrition.

b. Larynx.

(1) Paralysis of the larynx characterized by bilateral vocal cord paralysis seriously interfering with speech and adequate airway.

(2) Stenosis of the larynx of a degree causing respiratory embarrassment upon more than minimal exertion.

c. *Obstructive edema of glottis.* If chronic, not amenable to treatment, and requires a tracheotomy.

d. *Rhinitis.* Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting, concomitant severe headaches, and foul, fetid odor.

e. *Sinusitis.* Severe, chronic sinusitis that is suppurative, complicated by chronic or recurrent polyps, and that does not respond to treatment.

f. *Anosmia.* Permanent.

g. *Trachea.* Stenosis of the trachea.

3–30. Neurological disorders

The causes for referral to an MEB are as follows:

a. Amyotrophic lateral sclerosis and all other forms of progressive neurogenic muscular atrophy.

b. All primary muscle disorders including facioscapulohumeral dystrophy, limb girdle dystrophy, and myotonic dystrophy characterized by progressive weakness and atrophy.

c. Myasthenia gravis unless clinically restricted to the extraocular muscles.

d. Progressive degenerative disorders of the basal ganglia and cerebellum including Parkinson's disease, Huntington's chorea, hepatolenticular degeneration, and variants of Friedreich's ataxia.

e. Multiple sclerosis, optic neuritis, transverse myelitis, and similar demyelinating disorders.

f. Stroke, including both the effects of ischemia and hemorrhage, when residuals affect performance.

g. Migraine, tension, or cluster headaches, when manifested by frequent incapacitating attacks. All such Soldiers will be referred to a neurologist, who will ascertain the cause of the headaches. If the neurologist feels a trial of prophylactic medicine is warranted, a 3-month trial of therapy can be initiated. If the headaches are not adequately controlled at the end of the 3 months, the Soldier will undergo an MEB for referral to a PEB. If the neurologist feels the Soldier is unlikely to respond to therapy, the Soldier can be referred directly to MEB.

h. Narcolepsy, sleepwalking, or similar sleep disorders. (See para 3–41.) The evaluation and treatment of these diagnoses by a neurologist or other sleep specialist should be routinely sufficient.

i. Seizure disorders and epilepsy. Seizures by themselves are not disqualifying unless they are manifestations of epilepsy. However, they may be considered along with other disabilities in judging fitness. In general, epilepsy is disqualifying unless the Soldier can be maintained free of clinical seizures of all types by nontoxic doses of medications. The following guidance applies when determining whether a Soldier will be referred to an MEB.

(1) All active duty Soldiers with suspected epilepsy must be evaluated by a neurologist who will determine whether epilepsy exists and whether the Soldier should be given a trial of therapy on active duty or referred directly to an MEB for referral to a PEB. In making the determination, the neurologist may consider the underlying cause, EEG findings, type of seizure, duration of epilepsy, Family history, Soldier's likelihood of compliance with therapeutic program, absence of substance abuse, or any other clinical factor influencing the probability of control or the Soldier's ability to perform duty during the trial of treatment.

(2) If a trial of duty on treatment is elected by the neurologist, the Soldier will be given a temporary P–3 profile with as few restrictions as possible.

(3) Once the Soldier has been seizure free for 1 year, the profile may be reduced to a P–2 profile with restrictions specifying no assignment to an area where medical treatment is not available.

(4) If seizures recur beyond 6 months after the initiation of treatment, the Soldier will be referred to an MEB.

(5) Should seizures recur during a later attempt to withdraw medications or during transient illness, referral to a PEB is at the discretion of the physician or MEB.

(6) If the Soldier has remained seizure free for 36 months, they may be removed from profile restrictions.

(7) Recurrent pseudoseizures are most commonly seen in the presence of epilepsy. As such, they do not meet the standard under the same rules as epilepsy. While each case may be individualized, their evaluation by a neurologist should be routinely sufficient.

j. Any other neurologic conditions, Traumatic Brain Injury (TBI) or other etiology, when after adequate treatment there remains residual symptoms and impairments such as persistent severe headaches, uncontrolled seizures, weakness, paralysis, or atrophy of important muscle groups, deformity, uncoordination, tremor, pain, or sensory disturbance, alteration of consciousness, speech, personality, or mental function of such a degree as to significantly interfere with performance of duty.

Note.

Diagnostic concepts and terms used in paragraphs 3–31 through 3–37 are in consonance with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV). The minimum psychiatric evaluation will include Axis I, II, and III.

3–31. Disorders with psychotic features

The causes for referral to an MEB are as follows:

a. Diagnosed psychiatric conditions that fail to respond to treatment or restore the Soldier to full function within 1 year of onset of treatment.

b. Mental disorders not secondary to intoxication, infections, toxic, or other organic causes, with gross impairment in reality testing, resulting in interference with social adjustment or with duty performance.

3–32. Mood disorders

The causes for referral to an MEB are as follows:

a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or

b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or

c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

3–33. Anxiety, somatoform, or dissociative disorders

The causes for referral to an MEB are as follows:

a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or

b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or

c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

3–34. Dementia and other cognitive disorders due to general medical condition

The causes for referral to an MEB include persistence of symptoms or associated personality change sufficient to interfere with the performance of duty or social adjustment.

3–35. Personality, exhibitionism, transvestism, voyeurism, other paraphilias, or factitious disorders; disorders of impulse control not elsewhere classified

a. A history of, or current manifestations of, personality disorders, disorders of impulse control not elsewhere classified, transvestism, voyeurism, other paraphilias, or factitious disorders, psychosexual conditions, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis or dysfunctional residuals from surgical correction of these conditions render an individual administratively unfit. Commanders will address any questions or concerns regarding the application of these diagnoses to the appropriate supporting medical provider.

b. These conditions render an individual administratively unfit rather than unfit because of physical illness or medical disability. These conditions will be dealt with through administrative channels, including AR 135–175, AR 135–178, AR 635–200, or AR 600–8–24.

3–36. Adjustment disorders

Situational maladjustments due to acute or chronic situational stress do not render an individual unfit because of physical disability, but may be the basis for administrative separation if recurrent and causing interference with military duty.

3–37. Eating disorders

The causes for referral to an MEB are eating disorders that are unresponsive to treatment or that interfere with the satisfactory performance of duty.

3–38. Skin and cellular tissues

The causes for referral to an MEB are as follows:

a. *Acne*. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.

b. *Atopic dermatitis.* More than moderate, unresponsive to treatment, and which interferes with the Soldier's performance of duty.

c. *Amyloidosis.* Generalized.

d. *Cysts and tumors.* (See paras 3–42 and 3–43.)

e. Dermatitis herpetiformis. Not responsive to therapy.

f. Dermatomyositis.

g. *Dermographism.* Interfering with the performance of duty.

h. *Eczema, chronic.* Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.

i. Elephantiasis or chronic lymphedema. Not responsive to treatment.

j. Epidermolysis bullosa.

k. *Erythema multiforme.* More than moderate and recurrent or chronic.

l. Exfoliative dermatitis. Chronic.

m. *Fungal infections, superficial.* If not responsive to therapy and interfering with the satisfactory performance of duty.

n. Hidradenitis suppurative and/or folliculitis decalvans (dissecting cellulitis of the scalp). If unresponsive to treatment and interferes with the satisfactory performance of duty.

o. *Hyperhidrosis.* On the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial and not amenable to treatment.

p. Leukemia cutis or mycosis fungoides or cutaneous T–Cell lymphoma. (See also para 3–42.)

q. *Lichen planus.* Generalized and not responsive to treatment.

r. *Lupus erythematosus.* Cutaneous or mucous membranes involvement that is unresponsive to therapy and interferes with the satisfactory performance of duty.

s. *Neurofibromatosis.* When interfering with the satisfactory performance of duty.

t. *Panniculitis.* Relapsing, febrile, nodular.

u. *Parapsoriasis.* Extensive and not controlled by treatment.

v. *Pemphigus.* Not responsive to treatment and with moderate constitutional or systemic symptoms, or interfering with the satisfactory performance of duty.

w. *Psoriasis.* Extensive and not controllable by treatment.

x. *Radiodermatitis.* If resulting in malignant degeneration at a site not amenable to treatment.

y. *Scars and keloids.* So extensive or adherent that they seriously interfere with the function of an extremity or interfere with the performance of duty.

z. *Scleroderma*. Generalized or of the linear type that seriously interferes with the function of an extremity.

aa. Tuberculosis of the skin. (See paragraph 3–40.)

bb. *Ulcers of the skin*. Not responsive to treatment after an appropriate period of time if interfering with the satisfactory performance of duty.

cc. *Urticaria/Angioedema*. Chronic, severe, and not responsive to treatment.

dd. *Xanthoma.* Regardless of type, but only when interfering with the satisfactory performance of duty.

ee. *Intractable plantar keratosis, chronic.* Requires frequent medical/surgical care or that interferes with the satisfactory performance of duty.

ff. *Other skin disorders.* If chronic or of a nature that requires frequent medical care, or interferes with the satisfactory performance of military duty.

3–39. Spine, scapulae, ribs, and sacroiliac joints

The causes for referral to an MEB are as follows (see also para 3–14):

a. *Dislocation.* Congenital, of hip.

b. *Spina bifida.* Demonstrable signs and moderate symptoms of root or cord involvement.

c. *Spondylolysis or spondylolisthesis.* More than mild symptoms resulting in repeated outpatient visits, or repeated hospitalization or limitations effecting performance of duty.

d. *Coxa vara.* More than moderate with pain, deformity, and arthritic changes.

e. *Herniation of nucleus pulposus.* More than mild symptoms following appropriate treatment or remedial measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.

f. *Kyphosis.* More than moderate, interfering with military duties.

g. *Scoliosis.* Severe deformity with over 2 inches deviation of tips of spinous process from the midline, or of lesser degree if recurrently symptomatic and interfering with military duties.

h. Nonradicular pain involving the cervical, thoracic, lumbosacral, or coccygeal spine, whether idiopathic or secondary to degenerative disc or joint disease, that fails to respond to adequate conservative treatment and necessitates significant limitation of physical activity. Range of motion (ROM) measurements should be obtained using a goniometer (a bubble goniometer/inclometer is also acceptable). SF Form 527 should be used to document the ROM and the method of measurement. Use the VA's instructions for completion of spine and joint evaluations. This includes the six measurements shown on VASRD Plate V ROM of cervical and thoracolumbar spine.

3–40. Systemic diseases

The causes for referral to an MEB are as follows:

a. Amyloidosis.

b. *Brucellosis.* Chronic with substantiated, recurring febrile episodes, severe fatigue, lassitude, depression, or general malaise.

c. *Leprosy.* Any type that seriously interferes with performance of duty or is not completely responsive to appropriate treatment.

d. Myasthenia gravis.

e. *Mycosis, Blastomycosis, Coccidioidomycosis, and Histoplasmosis.* Active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals that themselves are unfitting.

f. Porphyria, cutanea tarda.

g. *Sarcoidosis.* Progressive with severe or multiple organ involvement and not responsive to therapy.

h. Tuberculosis.

(1) Meningitis, tuberculous.

(2) Pulmonary tuberculosis (see para 3–26), tuberculous empyema, and tuberculous pleurisy.

(3) Tuberculosis of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.

(4) Tuberculosis of the female genitalia.

(5) Tuberculosis of the kidney.

(6) Tuberculosis of the larynx.

(7) Tuberculosis of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery. These will be evaluated on an individual basis, considering the associated involvement, residuals, and complications.

i. *Rheumatoid arthritis.* That interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

j. *Spondyloarthropathies.* Chronic or recurring episodes of arthritis causing functional impairment interfering with successful performance of duty supported by objective, subjective, and radiographic findings, or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

(1) Ankylosingpondylitis.

(2) Reiter's syndrome.

(3) Psoriatic arthritis.

(4) Arthritis associated with inflammatory bowel disease.

(5) Whipple's disease.

k. *Systemic lupus erythematosus.* That interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

l. *Sjogren's syndrome.* When chronic, more than mildly symptomatic and resistant to treatment after a reasonable period of time.

m. *Progressive systemic sclerosis.* Diffuse and limited disease that interferes with successful performance of duty, or requires geographic assignment limitations, or requires medication for control that requires frequent monitoring by a physician due to debilitating, or serious side effects.

n. *Myopathy.* To include inflammatory, metabolic or inherited, that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

o. *Systemic vasculitis.* Involving major organ systems, chronic, that interferes with successful performance of duty, or requires geographic assignment limitations, or requires medication for control that requires frequent monitoring by a physician due to debilitating, or serious side effects.

p. *Hypersensitivity angiitis.* When chronic or having recurring episodes that are more than mildly symptomatic or show definite evidence of functional impairment which is resistant to treatment after a reasonable period of time.

q. *Behcet's syndrome.* That interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

r. *Adult onset Still's disease.* That interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

s. Mixed connective tissue disease and other overlap syndromes. That interfere with successful performance of duty or require geographic assignment limitations or require medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

t. Exertional rhabdomyolysis. The diagnosis of exertional rhabdomyolysis, defined as severe exercise-induced muscle pain resulting from repetitive exercise with an elevation of serum creatine kinase (CK) generally at least 5 times the upper limit of the lab normal range or urine myoglobin, will be referred to a MEB if the Soldier has—

(1) Recurrent episodes of exertional rhabdomyolysis; or

(2) A single episode with severe systemic complications (for example, compartment syndrome); or

(3) A single episode results in physical complications that interfere with successful performance of duty.

(4) Soldiers with any of the following symptoms 2 weeks after experiencing an episode of exertional rhabdomyolyis should be referred to the appropriate specialist for consideration of referral to an MEB:

(a) Persistent residual kidney injury; or

(b) Persistent elevation of serum CK 5 times the upper limit of the lab normal range or delayed clinical recovery; or

(c) A history of sickle cell trait.

(5) The Uniformed Services University Consortium for Health and Military Performance (CHAMP) (http://champ.usuhs.mil) is available electronically to assist in clinical consultation at champ@usuhs.mil. In addition, a Clinical Practice Guideline in the Management of Exertional Rhabdomyolysis in Soldiers is available at: http://champ.usuhs.mil/chclinicaltools.html.

u. Any chronic or recurrent systemic inflammatory disease or arthritis not listed above. That interferes with successful performance of duty or requires geographic assignment limitations, or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

3–41. General and miscellaneous conditions and defects

The causes for referral to an MEB are as follows:

a. Allergic manifestations.

(1) Allergic rhinitis, chronic, severe, and not responsive to treatment. (See also paras 3–29*d* and 3–29*e*.)

(2) Asthma. (See para 3–27*a*.)

(3) Allergic dermatoses. (See para 3–38.)

b. *Cold injury/heat injury.* (See paras 3–45 and 3–46.)

c. *Sleep apnea.* Obstructive sleep apnea or sleep-disordered breathing that causes daytime hypersomnolence or snoring that interferes with the sleep of others and that cannot be corrected with medical therapy, nasal continuous positive airway pressure (CPAP), surgery, or an oral appliance. The diagnosis must be based upon a nocturnal polysomnogram and the evaluation of a pulmonologist, neurologist, or a privileged provider with expertise in sleep medicine.

(1) A 12-month trial of therapy with nasal continuous positive air pressure may be attempted to assist with other therapeutic interventions, during which time the individual will be issued a temporary profile. Soldiers with severe sleep apnea and/or symptoms may be referred directly for an MEB. If nasal CPAP is required for longer than 12 months, the Soldiers should be profiled as a permanent P2.

(2) If symptoms of hypersomnolence or snoring can not be controlled with medical therapy, nasal CPAP, surgery or an oral appliance, the individual should be referred for a MEB. If the use of nasal CPAP or other therapies for sleep apneas result in interference with satisfactory performance of duty as substantiated by the individual's commander or supervisor, the Soldier should be referred to a MEB.

d. *Fibromyalgia.* When severe enough to prevent successful performance of duty. Diagnosis will include evaluation by a rheumatologist.

e. *Miscellaneous conditions and defects.* Conditions and defects not mentioned elsewhere in this chapter are causes for referral to an MEB, if—

(1) The conditions (individually or in combination) result in interference with satisfactory performance of duty as substantiated by the individual's commander or supervisor. Any medical condition, injury or defect (individually or in combination) that prevents the Soldier from performing any of the functional activities listed under item number 5 on DA Form 3349 (Physical Profile).

(2) The individual's health or well-being would be compromised if they were to remain in the military service.

(3) In view of the Soldier's condition, their retention in the military service would prejudice the best interests of the Government (for example, a carrier of communicable disease who poses a health threat to others). Questionable cases, including those involving latent impairment, will be referred to PEBs.

3–42. Malignant neoplasms

The causes for referral to an MEB are as follows:

a. Malignant neoplasms that are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

b. Neoplastic conditions of the lymphoid and blood-forming tissues that are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

c. Malignant neoplasms, when on evaluation for administrative separation or retirement, the observation period subsequent to treatment is deemed inadequate in accordance with accepted medical principles.

d. The above definitions of malignancy or malignant disease exclude basal cell carcinoma of the skin.

3–43. Benign neoplasms

The causes for referral to an MEB are as follows:

a. Benign tumors if their condition precludes the satisfactory performance of military duty.

b. Ganglioneuroma.

c. Meningeal fibroblastoma, when the brain is involved.

d. Pigmented villonodular synovitis when severe enough to prevent successful performance of duty.

3–44. Sexually transmitted diseases

The causes for referral to an MEB are as follows:

a. Symptomatic neurosyphilis in any form.

b. Complications or residuals of a sexually transmitted disease of such chronicity or degree that the individual is incapable of performing useful duty.

3–45. Exertional heat illness

General. Exertional heat illness represents a continuum in severity, and includes heat exhaustion, heat injury, and heat stroke. Heat stroke should be the working diagnosis for any Soldier with profound altered mental status. Final diagnosis should be delayed until the entire clinical picture is evident. The causes for referral to an MEB are as follows:

a. Heat exhaustion (HE) is defined as a syndrome of hyperthermia (core temperature at time of event usually ≤40ºC or 104ºF) with physical collapse or debilitation occurring during or immediately following exertion in the heat, with no more than minor central nervous system (CNS) dysfunction (such as headache, dizziness). HE resolves rapidly with minimal cooling intervention.

(1) Individual episodes of HE are not cause for referral to a MEB. However, Soldiers who experience three episodes of HE in less than 24 months, require referral to an MEB.

(2) Soldiers diagnosed with HE are individually profiled as determined by the treating privileged provider. Soldiers with HE pending referral to a MEB will be profiled using guidance provided in table 3–2.

b. Heat injury (HI) is defined as HE with clinical evidence of organ (for example, liver, renal, stomach) and/or muscle (for example, rhabdomyolysis) damage without sufficient neurological symptoms to be diagnosed as heat stroke.

(1) Single episodes of HI are not cause for an immediate referral to a MEB. However, Soldiers who experience three episodes of HI in less than 24 months or a single episode with severe complications (for example, compartment syndrome) of such a nature that the complications interfere with successful performance of duty, require referral to a MEB. Soldiers demonstrating any of the following complications, despite two weeks of rest, should be referred to the appropriate medical specialist for consideration of referral to a MEB: persistent residual kidney injury; persistent elevation of serum creatine kinase (CK) more than 5 times the upper limit of the lab normal range or persistent elevation of transaminases more than three times the upper limit of the lab normal range.

(2) All Soldiers diagnosed with HI will be placed on a temporary profile, numerical designator 4 in the PULHES physical capacity factor P, (T4-(P)), for a period of 1 week. After the 1-week period, the Soldier will be reevaluated and individually profiled as determined by the treating privileged provider. Soldiers diagnosed with HI and pending referral to a MEB will be profiled using guidance provided in table 3–2.

c. Heat stroke (HS) is defined as a syndrome of hyperthermia (core temperature at time of event usually ≥ 40ºC or 104ºF), physical collapse or debilitation, and encephalopathy as evidenced by delirium, stupor, or coma, occurring during or immediately following exertion or significant heat exposure. The HS can be complicated by organ and/or tissue damage, systemic inflammatory activation, and disseminated intravascular coagulation.

(1) Following an episode of HS, the Soldier will be placed on a T4-(P) profile for a period of 2 weeks. After the 2-week period, the Soldier will be reevaluated weekly for the need of a continuing profile and/or referral to a MEB. This reevaluation will include an assessment for the presence or absence of physical damage and/or complications and any contributing risk factor(s) that may have increased the Soldier's inability to tolerate the heat exposure. For profile guidance, see table 3–2.

(2) During the reevaluation period, the Soldier will be classified into one of the following three categories: HS without sequelae demonstrated by all clinical signs and symptoms resolved by 2 weeks following the heat exposure event; HS with sequelae to include any evidence of cognitive or behavioral dysfunction, renal impairment, hepatic dysfunction, rhabdomyolysis, or other related pathology that does not completely resolve by 2 weeks following the heat exposure event; or complex HS that is recurrent, or occurring in the presence of a non-modifiable risk factor, either known (for example, a chronic skin condition such as eczema or burn skin graft) or suspected (for example, sickle cell trait or malignant hyperthermia susceptibility).

(3) Soldiers with complex HS require referral to a MEB. The Soldier's provider should consider referring the Soldier to a center with clinical expertise in heat illness for further evaluation.

d. Initial entry training Soldiers will not be separated based upon the diagnosis of one episode of HS with or without complications, but will be placed into a Warrior Training and Rehabilitation Program (WTRP) (formally the Physical Training and Rehabilitation Program (PTRR)) for the duration of their profile.

e. The Uniformed Services University Consortium for Health and Military Performance (CHAMP) (http://champ.usuhs.mil) is available electronically to assist in clinical consultation at champ@usuhs.mil. The U.S. Army Research Institute of Environmental Medicine (USARIEM) (www.usariem.army.mil) and U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) (http://chppm-www.apgea.army.mil/) are subject matter experts in heat physiology, acclimation and related operational issues, and offer valuable clinical and educational resources.

3–46. Cold injury

The causes for referral to an MEB are as follows:

a. Frostbite (freezing cold injury).

(1) The definition of frostbite is the consequence of freezing of tissue. First degree frostbite is manifested by superficial injury without blistering. Second degree frostbite is manifested by superficial injury with clear blisters with only epidermal tissue loss. Third degree and fourth degree frostbite are manifested by significant subepidermal tissue loss.

(2) Soldiers with first degree frostbite after clinical healing will be given a permanent P–2 profile permitting the use of extra cold weather protective clothing, including nonregulation items, to be worn under authorized outer garments.

(3) Soldiers with frostbite more than first degree will be given a P–3 profile, renewed as appropriate, for the duration of the cold season restricting them from any exposure to temperatures below 0 degrees C (32 degrees F) and from any activities limited by the remainder of the season. After the cold season, Soldiers will be reevaluated and, if appropriate, given the P–2 profile described in (2), above.

(4) Soldiers will be referred to an MEB for recurrent cold injury, recurrent or persistent cold sensitivity despite the P–2 profile, vascular or neuropathic symptoms, or disability due to tissue lost from cold injury.

b. Trench foot (nonfreezing cold injury).

(1) The definition of trench foot is the consequence of prolonged cold immersion of an extremity. It is manifested by maceration of tissue and neurovascular injury.

(2) Soldiers with residual symptoms or significant tissue loss after healing will be referred to an MEB.

c. Accidental hypothermia.

(1) The definition of accidental hypothermia is clinically significant depression of body temperature due to environmental cold exposure.

(2) Soldiers with significant symptoms of cold intolerance or a recurrence of hypothermia after an episode of accidental hypothermia will be referred to an MEB.

Table 3–1
Methods of assessing cardiovascular disability

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification	Specific activity scale (Goldstein et al: Circulation 64:1227, 1981)	New York Heart Association Functional Classification (Revised)
I.	Patient with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, dyspnea, or anginal pain.	Ordinary physical activity, such as walking and climbing, stairs, does not cause angina. Angina with strenuous or rapid or prolonged exertion at work or recreation.	Patients can perform to completion any activity requiring 7 metabolic equivalents: for example, can carry 24 lbs up eight steps, carry objects that weigh 80 lbs, do outdoor work. (shovel snow, spade soil), do recreational activities (skiing, basketball, handball, jog, and walk 5 mph).	Cardiac status uncompromised.

Table 3–1
Methods of assessing cardiovascular disability—Continued

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification	Specific activity scale (Goldstein et al: Circulation 64:1227, 1981)	New York Heart Association Functional Classification (Revised)
II.	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.	Slight limitations of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, in wind, or when under emotional stress, or only during the few hours after awakening. Walking more than 2 blocks on the level and climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.	Patient can perform to completion any activity requiring ≥5 metabolic equivalents, but cannot and does not perform to completion activities requiring metabolic equivalents: for example, have sexual intercourse without stopping, garden, rake, weed, roller skate, dance fox trot, walk at 4 mph on level ground.	Slightly compromised.
III.	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.	Marked limitation of ordinary physical activity. Walking one to two blocks on the level and climbing more than one flight in normal conditions.	Patient can perform to completion any activity requiring ≥2 metabolic equivalents but cannot and does not perform to completion activities requiring ≥5 metabolic equivalents: for example, shower without stopping, strip and make bed, clean windows, walk 2.5 mph, bowl, play golf, dress without stopping.	Moderately compromised.
IV.	Patient with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.	Inability to carry on any physical activity without discomfort—anginal syndrome may be present at rest.	Patient cannot or does not perform to completion activities requiring ≥2 metabolic equivalents. Cannot carry activities listed above (specify activity scale, Class III).	Severely compromised.

New York Heart Association Therapeutic Classification

Therapeutic Classification				Revised classification (prognosis)
Class A–	Patients with cardiac disease whose physical activity need not be restricted			Class I—Good.
Class B–	Patients with cardiac disease whose ordinary activity need not be restricted, but who should be advised against severe or competitive physical efforts.			Class II—Good with therapy.
Class C–	Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.			Class III—Fair with therapy.
Class D–	Patients with cardiac disease who should be at complete rest, confined to bed or chair.			Class IV—Guarded despite therapy.

METS Equivalents (Required for PEB adjudication)

Class I = 8 METS or greaterClass II = 5–8 METSClass III = 3–5 METSClass IV = Less than 3 METS

Table 3–2
Profile progression recommendations for the Soldier with heat stroke, with or without Sequelae, complex heat stroke, heat exhaustion, or heat injury, pending a medical evaluation board

Profile code*	Restrictions**	Heat stroke without Sequelae	Heat stroke with Sequelae	Complex heat stroke or heat exhaustion/heat injury pending MEB
T -4 (P)	Complete duty restrictions.	2 weeks	2 week minimum, advance when clinically resolved.	2 week minimum, advance when clinically resolved.
T -3 (P)	Physical Training and running/walking/swimming/bicycling at own pace and distance not to exceed 60 min per day. No maximal effort; no APFT; no wear of IBA; no MOPP gear; no ruck marching. No airborne operations (AO).	1 month minimum	2 months minimum	Pending MEB
T -3 (P)	Gradual acclimatization (TB Med 507). No maximal effort; no APFT; no MOPP IV gear. IBA limited to static range participation. May ruck march at own pace and distance with no more than 30 lbs. Non tactical AO permitted.	1 month minimum	2 months minimum***	N/A
T -2 (P)	Continue gradual acclimatization. May participate in unit PT; CBRN training with MOPP gear for up to 30 min; IBA on static and dynamic ranges for up to 45 min; no record APFT. Ruck march at own pace and distance with no more than 30 lbs up to 2 hrs. Non-tactical AO permitted.	N/A	Pending completion of 30 day heat exposure requirement, if not accomplished during prior profile***	N/A

Notes:
*__T__ emporary Profile; Physical Category P (__P__ ULHES). **Soldiers manifesting no heat illness symptomatology or work intolerance after completion of profile restrictions can advance and return to duty without a MEB. Any evidence/manifestation of heat illness symptomatology during the period of the profile requires a MEB referral. ***HS with Sequelae return to full duty requires a minimum period of heat exposure during environmental stress (Heat Category 2 during the majority of included days).

Chapter 4
Medical Fitness Standards for Flying Duty

4–1. General

a. In this regulation, the term “flying duty” is synonymous with “flight status” and “aviation service.” The term “aircrew” or “aircrew member” applies to rated and non-rated personnel in aviation service, unmanned aerial systems (UAS), and air traffic control. All provisions apply to the AA, USAR, and the ARNG/ARNGUS.

b. The aviation medicine consultant (AMC) to TSG will recommend to TSG a senior specialist in aerospace medicine to be placed on orders for designation as the Director, U.S. Army Aeromedical Activity (USAAMA). Responsibilities will include all administrative actions and medical fitness standards for flying duty for all active and RC/NG Army aviators. The U.S. Army Aeromedical Activity is located at Building 301, Dustoff Street, Fort Rucker, AL 36362–5333.

c. Provisions in this chapter are subject to NATO Standardization Agreement (STANAG) 3526, which applies to allied nation aircrews serving with U.S. Forces or attending U.S. Army training programs, and to U.S. aircrews serving with foreign forces (see Aeromedical Technical Bulletins (ATB), International Military Students for additional guidance at: https://aamaweb.usaama.rucker.amedd.army.mil/).

d. This chapter lists medical conditions and physical defects that are causes for rejection in selection, training, and retention of—

(1) Army aviators.

(2) DA civilian (DAC) pilots and contract civilian pilots who are employed by firms under contract to DA.

(3) Flight surgeons (FSs) (AOC 61N), aeromedical physician assistants (APAs) (AOC 65 DM3), and aviation medicine nurse practitioners (AMNP) (AOC 66NP1). Aviation medical examiners (AME defined in para 6–9*f*) and DAC/contract civilian FS/APA/AMNP are not required to meet these standards.

(4) Military, DAC, and DA contract air traffic controllers (ATCs).

(5) Individuals ordered by competent authority to participate in regular flights as nonrated aircrew and UAS operators.

(6) Applicants for special flight training programs directed by DA or National Guard Bureau (NGB), such as Army ROTC or USMA flight training programs.

(7) Aircrew of allied host nations or U.S. Government agencies other than DA who are flying Army aircraft, unless superseded by agreements with that nation or agency.

e. A failure to meet medical standards for flying duties remains disqualifying for flying duties until reviewed by the USAAMA. The USAAMA may recommend qualified, qualified with waiver, or medical suspension from aviation service. The USAAMA issues Aeromedical Policy Letters (APLs) and ATBs that provide detailed recommendations for specific, common disqualifications. Refer all questionable cases to the USAAMA, Fort Rucker, AL 36362–5333.

4–2. Classes of medical standards for flying and applicability

The classes of medical fitness standards for flying duties are as follows:

a. Class 1 (warrant officer candidate, commissioned officer or cadet) standards apply to—

(1) Applicants for aviator training. (See also AR 611–110.)

(2) Applicants for special flight training programs directed by DA or NGB, such as Army ROTC or USMA flight training programs.

(3) Other non-U.S. Army personnel selected for training until the beginning of training at aircraft controls, or as determined by Chief, Army Aviation Branch.

b. Class 2 standards apply to—

(1) Student aviators after beginning training at aircraft controls or as determined by Chief, Army Aviation Branch.

(2) Rated Army aviators (AR 600–105).

(3) The DAC pilots.

(4) Contractor pilots will have the option, as specified in the contract, of maintaining either a current annual Federal Aviation Administration (FAA) Class 2 Medical Certificate or an Army Class 2 Flying Duty Medical Examination (FDME). Army Aeromedical Surveillance is an integral part of Army Aviation Risk Management. Therefore, contractor aircrew who opt for the annual FAA certificates must submit a copy of the annual FAA certificate, with any applicable Statement of Demonstrated Ability (SODA) or FAA waiver, to USAAMA and give permission to the FAA to provide their medical information to the U.S. Army Aeromedical Activity in order to continue population-based medical surveillance and ensure risks to flight safety are minimized. The aforementioned information will be mailed to USAAMA (MCXY–AER), Building 301, Dustoff Street, Fort Rucker, AL 36362; or faxed to commercial 334–255–7030 ext. 7060 (DSN 558); or scanned and e-mailed to aama@amedd.army.mil.

(5) Army aviators considered for return to aviation Service.

(6) When directed by DA or NGB under special procurement programs for initial Army aviation flight training, selected senior career officers of the Army may be medically qualified under Army Class 2 medical standards.

(7) Applicants to DA or NGB civilian-acquired aeronautical skills programs.

(8) Other non-U.S. Army personnel.

c. Class 2F/2P standards apply to—

(1) The FSs (AR 600–105); APAs and AMNPs (AR 600–106).

(2) Medical officers, medical students, nurse practitioners, and physician assistants applying for or enrolled in the Army Flight Surgeon Primary Course.

d. Class 3 standards apply to non-rated crewmembers (AR 600–106). Soldiers and civilians ordered by a competent authority to participate in regular flights in Army aircraft, but who do not operate aircraft flight controls. These include crew chiefs, aviation maintenance technicians, aerial observers, gunners; unmanned aircraft system operators (UASO), nonrated (AR 600–106) medical personnel selected for aeromedical training, such as flight medical aidmen, psychologists, and others (see para 4–32). Army civilian contractor non-rated crewmembers will have the option, similar to paragraph 4–2*b*(4), of maintaining either an annual FAA Class 3 Medical Certificate or DD Form 2992 (Medical Recommendation for Flying or Special Operational Duty).

e. Class 4 standards apply to military ATCs. Civilian ATCs are required to meet Class IV OPM standards (see ATB, ATC Civilian Standards, DAC, and contract).

4–3. Aeromedical consultation

Aeromedical administration is detailed in chapter 6. Questions pertaining to aeromedical consultation, policy, standards, and administration should be directed to the USAAMA, Fort Rucker, AL 36362–5333.

4–4. Abdomen and gastrointestinal system

The causes for medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes listed in paragraph 2–3, plus the following:

a. Abdominal fistula or sinus.

b. Small and large intestine.

(1) History of bowel resection for any cause, with the exception of appendectomy.

(2) History of any procedures for the relief of intestinal obstruction, adhesions, or intussusception, with the exception of uncomplicated pylorotomy or intussusception in childhood.

(3) History of functional bowel syndrome (irritable colon), megacolon, diverticulitis, diverticulosis with complications, regional enteritis (Crohn's disease), ulcerative colitis, or proctitis.

c. Hepato-pancreato-biliary tract.

(1) Enlargement of the liver, except when the liver function tests are normal and the condition does not appear to be caused by active disease.

(2) Cholelithiasis.

(3) Cholecystectomy until recovery is complete or history of sequelae to cholecystectomy listed in paragraph 2–3.

d. *History of gastrointestinal bleeding.* This excludes minor bleeding from hemorrhoids or acute rectal fissure. (See APLs, Peptic Ulcer Disease.)

4–5. Blood and blood–forming tissue diseases

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraph 2–4, plus the following:

a. Anemia, of any etiology.

(1) Males with a hematocrit (HCT) less than 40 percent, or females with an HCT less than 37 percent; or

(2) If a complete hematologic evaluation results in the diagnosis of physiologic anemia, or anemia due to sickle cell trait or beta thalassemia minor; males with a HCT less than 38 percent, or females with a HCT less than 35 percent. (See APL, Hematocrit, and Hemoglobinopathies.)

b. *History of immunodeficiency diseases.* (See also para 2–35*l*.) Civilian employees are not disqualified based solely on the presence of the HIV virus. (See AR 600–110 and ATB 2, Army Flight Surgeon's Administrative Guide.)

c. *History of splenectomy.* For any reason, except trauma.

d. Thrombophlebitis.

(1) Acute, superficial thrombophlebitis until resolved.

(2) History of deep vein thrombophlebitis, thrombosis of any deep vessel, or thromboembolism.

4–6. Dental

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraph 2–5, plus the following:

a. Orthodontic appliances, if they interfere with effective oral communication, or pose a hazard to personal or flight safety.

b. Dental Fitness Class 3 or 4, until the abnormalities or deficiencies have been corrected (see APL, Dental Fitness).

4–7. Ears

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraph 2–6, plus the following:

a. *Infection.* Any infectious process of the ear until completely healed, except mild asymptomatic external otitis.

b. External ear.

(1) Deformities of the pinna that cause distractions or hearing loss while wearing protective headgear.

(2) History of post auricular fistula.

c. Middle ear.

(1) Barotitis media, until resolved.

(2) History of cholesteatoma.

(3) History of chronic or recurrent Eustachian tube dysfunction.

(4) Otosclerosis.

(5) History of simple, radical, or modified radical mastoidectomy.

(6) Any surgical procedure in the middle ear that includes fenestration of the oval window or horizontal semicircular canal, any endolymphatic shunting procedure, stapedectomy, the use of any prosthesis or graft, or reconstruction of the stapes.

(7) Tympanoplasty, until completely healed with acceptable hearing and motility, as documented by current ear–nose–throat evaluation.

d. Inner ear.

(1) Abnormal labyrinthine function.

(2) History of perilymph fistula.

(3) Tinnitus, except when associated with high frequency hearing loss.

(4) History of vertigo, except physiologic vertigo induced by gravity forces, aircraft spins, or Baranay chair.

4–8. Hearing

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 is hearing loss in dB greater than shown in table 4–1. (See APL, Audiometric Evaluation.)

4–9. Endocrine and metabolic diseases

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes listed in paragraph 2–8, plus a history of symptomatic hypoglycemia. (See APL, Diabetes and Glucose Intolerance.)

4–10. Extremities

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraphs 2–9, 2–10, 2–11, and 4–22, plus dimensions, loss of strength or endurance, or limitation in motion that compromises flying safety. Orthopedic hardware is disqualifying until reviewed by the USAAMA. (See APL, Retained Hardware.)

4–11. Eyes

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraph 2–12, plus the following:

a. Lids and conjunctiva.

(1) Epiphora (chronic tearing).

(2) Trachoma, unless healed without cicatrices.

b. Cornea.

(1) Complications secondary to use of contact lenses or a history of orthokeratologic procedures to correct refractive error may be disqualifying. Contact lens use requires annual followup. (See APL, Contact Lens Wear.)

(2) History of herpetic corneal ulcer or keratitis—acute, chronic, or recurrent.

(3) Pterygium that encroaches on the cornea more than 1 mm or is progressive, or for Classes 1, history of surgical removal of a pterygium within the last 12 months.

c. History of ocular surgery to include refractive surgery and/or interocular lens implant. (See APL, Corneal Refractive Surgery.)

d. Uveal tract.

(1) Coloboma of the choroid or iris.

(2) History of inflammation of the uveal tract, acute, chronic, or recurrent; including anterior uveitis, peripheral uveitis or pars planitis, posteri or uveitis, or traumatic iritis.

e. Retina.

(1) History of central serous retinopathy.

(2) History of chorioretinitis, including evidence of presumed ocular histoplasmosis syndrome.

(3) History of retinal holes or tears.

f. Optic nerve.

(1) Optic nerve drusen or hyaline bodies of the optic nerve.

(2) History of optic or retrobulbar neuritis.

g. Ocular motility.

(1) History of extraocular muscle surgery after age 4, or history of extraocular muscle surgery before age 4 with other residual ocular abnormalities.

(2) Monofixation syndrome (microtropias).

h. Miscellaneous defects and diseases.

(1) Glaucoma as evidenced by applanation tension 30 mmHg or higher, or secondary changes in the optic disc or visual field associated with glaucoma. (See APL, Glaucoma and Ocular Hypertension.)

(2) Intraocular hypertension as evidenced by two or more determinations of 22 mmHg or higher, or a persistent difference of 4 or more mmHg tension between the two eyes, when confirmed by applanation tonometry. (See APL, Glaucoma and Ocular Hypertension.)

(3) History of penetrating trauma to the eye or hyphema.

(4) History of ocular or acephalic migraine with visual disturbance.

4–12. Vision

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the following:

a. *Class 1.* Any disqualifying condition must be referred to optometry or ophthalmology for verification.

(1) *Distant visual acuity.* Uncorrected distant visual acuity worse than 20/50 in each eye. If the distant visual acuity is 20/50 or better in either eye, each eye must be correctable to 20/20 with no more than 1 error per 5 presentations of 20/20 letters, in any combination, on either the Armed Forces Vision Tester (AFVT) or any projected Snellen chart set at 20 feet. (See ATB, Distant Visual Acuity Testing and APL, Decreased Visual Acuity.)

(2) *Near visual acuity.* Uncorrected near visual acuity worse than 20/20 in each eye; with no more than 1 error per 5 presentations of 20/20 letters, in any combination, on the AFVT or any Snellen near visual acuity card. (See ATB, Near Visual Acuity Testing and APL, Decreased Visual Acuity.)

(3) *Cycloplegic refractive error using the method in ATB, Cycloplegic Refraction.*

(a) Hyperopia greater than +3.00 diopters of sphere in any meridian by transposition in either eye. (Spherical equivalent method does not apply.)

(b) Myopia greater than –1.50 diopters of sphere in any meridian by transposition in either eye. (Spherical equivalent method does not apply.)

(c) Astigmatism greater than +/–1.00 diopter of cylinder in either eye.

(4) *Ocular motility.* (See ATB, Ocular Motility Testing; APL, Excessive Phorias; and APL, Convergence Insufficiency.)

(a) Any degree of tropia detected in ocular motion on the Cover-Uncover Test (Unilateral Cover Test or Tropia Test).

(b) Esophoria greater than 8 prism diopters.

(c) Exophoria greater than 8 prism diopters.

(d) Hyperphoria greater than 1 prism diopter.

(e) Near point of convergence (NPC) greater than 100 mm.

(5) *Color vision.* (See ATB, Color Vision Testing and APL, Color Vision Abnormalities.)

(a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate (PIP) Set; or

(b) Any error in reading the nine test light pairs of the Farnsworth Lantern (FALANT) or the OPTEC 900 Color Vision Tester.

(6) *Binocular depth perception (stereo acuity) worse than 40 seconds of arc.* (See ATB, Depth Perception Testing and APL, Defective Depth Perception.)

(a) Any error in Group B of the AFVT (40 seconds of arc); or

(b) Any error in levels 1 through 7 of the 10 levels of three circles each in the Random Dot (RANDOT) Circles Test; or

(c) Any error in levels 1 through 9 of the 9 levels of four circles each in the Titmus Graded Circles Stereoacuity Test.

(7) *Field of vision.* Any scotoma, other than physiologic blindspot. (See ATB, Field of Vision Testing.)

(8) *Night vision.* As noted by history. (There is currently no definitive test or score.) Any ocular abnormalities resulting in decreased night vision must be referred to ophthalmology for confirmation. (See ATB, Night Vision.)

b. Classes 2/2F/3/4. Same as Class 1, except as listed below:

(1) *Distant and near visual acuity.* Uncorrected acuity worse than 20/400 in either eye at distance or near, or vision not correctable to 20/20 in each eye as outlined in paragraph 4–12*a*(1) and (2).

(2) *Manifest refractive error.* Refractive error of such magnitude that the individual cannot be fit with aviation spectacles.

(3) *NPC of greater than 100 mm.* This is not disqualifying but must be referred to Ophthalmology or Optometry for evaluation. (See ATB, Ocular Motility Testing; APL, Excessive Phorias; and APL, Convergence Insufficiency.)

4–13. Genitourinary

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraphs 2–14 and 2–15, plus the following:

a. History of persistent hematuria with greater than five red blood cells per high power field on routine analysis.

b. History of any metabolic abnormality of the urine, to include proteinuria, glycosuria, and hypercalcinuria.

c. Uncomplicated pregnancy is not disqualifying, but results in flying duty restrictions. (See APL, Pregnancy.) In uncomplicated pregnancies, flying is restricted to synthetic flight simulator training during the entire pregnancy; or multicrew, multi-engine, non-ejection seat fixed wing aircraft during the 13th through 24th week of gestation. The requirement for physiological training is waived during pregnancy.

d. Complications of pregnancy. (See APL, Pregnancy.)

e. History of urinary tract stone formation or retention of urinary tract stone within collecting system. (See APL, Kidney Stones, and APL, Pregnancy.)

4–14. Head and neck

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraphs 2–16, 2–17, and 4–22.

4–15. Heart and vascular system

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraphs 2–18 and 2–19, plus the following:

a. History of any abnormal electrocardiographic findings, including but not limited to:

(1) Left axis deviation greater than minus 45 degrees.

(2) Acquired right axis deviation greater than 120 degrees.

(3) First degree AV-block when the PR interval (interval between the P and R waves on an electrocardiogram (EKG)) cannot be shortened to less than or equal to 220 milliseconds in the unipolar leads during exercise.

(4) Mobitz Type II second degree AV block, and third degree AV block.

(5) Acquired left anterior or posterior hemiblock.

(6) Acquired complete right bundle branch block. (See APL, Acquired Right Bundle Branch Block.)

(7) Complete left bundle branch block.

(8) Pre-excitation as manifested by Wolff-Parkinson-White pattern or short PR interval (PR interval less than 120 milliseconds in all 12 leads). Wolff-Parkinson-White syndrome.

(9) Sinus pause or asystole accompanied by symptoms and/or greater than 2.2 seconds in duration.

(10) Bradydysrhythmias accompanied by symptoms and/or hypotension.

(11) Supraventricular tachycardia (3 or more beats at a rate greater than 100) to include atrial fibrillation/flutter, multifocal atrial tachycardia, junctional tachycardia, and persistent sinus tachycardia.

(12) Frequent uniform or multiform ventricular premature beats, or ventricular premature beats, or ventricular premature beat pairs, as defined by APL, Abnormal Electrocardiogram.

(13) Ventricular tachycardia (3 or more beats at a rate greater than 100), to include ventricular fibrillation/flutter and accelerated idioventricular rhythm.

(14) Acquired ST and T wave abnormalities consistent with myocardial dysfunction of any etiology.

(15) Aeromedically abnormal exercise treadmill test as defined by ATB, Aeromedical Graded Exercise Test, until reviewed by the USAAMA. (See APL, Abnormal Cardiac Function Testing.)

b. History of hypertrophic, dilated, or obstructive cardiomyopathy, to include left ventricular hypertrophy, as documented by clinical or EKG evidence. Hypertrophy due to athletic heart is not disqualifying. (See APL, Aeromedical Cardiovascular Screening Program.)

c. History of valvular heart disease, to include mitral valve prolapse, as documented by clinical or electrocardiographic findings.

d. History of myocarditis, or endocarditis, to include subacute bacterial endocarditis. History of pericarditis until reviewed by the USAAMA.

e. Any evidence of coronary artery disease as outlined by APL, Aeromedical Cardiovascular Screening Program.

f. For Classes 2/2F, suspected coronary artery disease such as an elevated cardiac risk index, elevated total cholesterol or cholesterol/high-density lipoprotein (HDL) -cholesterol ratio in conjunction with an abnormal aeromedical graded exercise treadmill test and/or abnormal cardiac fluoroscopy as outlined in APL, Aeromedical Cardiovascular Screening Program. (See also ATB 6, Aeromedical Graded Exercise Test, and ATB 9, Cardiac Fluoroscopy.)

g. History of congenital anomalies of the heart or great vessels, or surgery to correct these anomalies.

h. History of cor pulmonale or congestive heart failure.

i. History of hypertension with a systolic pressure of 140 mmHg or greater, and/or diastolic pressure of 90 mmHg or greater, with or without systemic complications confirmed by average reading of a 3-day blood pressure check. (See APL, Hypertension in Aircrew Members.)

j. Orthostatic hypotension or orthostatic intolerance or symptomatic hypotension. (See para 4–22*e*.)

k. History of diseases of the blood and lymphatic vessels, to include but not limited to, aortic aneurysm, arteriosclerotic occlusive disorders, fistulas, vasculitis, vasospastic disorders, thromboembolic disorders, and lymphedema.

l. History of any cardiac surgical procedure, to include pacemaker insertion, valve replacement, bypass tract ablation by any method, coronary angioplasty, and coronary artery bypass.

4–16. Linear anthropometric dimensions

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the following:

a. *Initial Classes 1/2/2F*. Failure to meet linear anthropometric standards. Total arm reach equal to or greater than 164.0cm. Sitting height equal to or less than 102.0 cm. Crotch height equal to or greater than 75.0 cm. (See ATB, Anthropometry.)

b. *Class 3*. Linear anthropometric measurements and body composition not compatible with aviation or crew member safety, or operational effectiveness at the Class 3 aircrew member's workstation.

4–17. Weight and body build

Aircrew members are medically unfit for flying duty Classes 1/2/2F/3/4 when the body weight or build prevents normal functions required for safe and effective aircraft flight such as interference with aircraft instruments, controls, and aviation life support equipment, to include proper function of crash worthy seats, ejection seats, and other mechanisms of egress. (Military aircrew members may be subject to administrative restriction from flying duty by their commander when body weight or composition exceeds the limits prescribed by AR 600–9.)

4–18. Lung and chest wall

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraphs 2–23 and 4–2, plus the following:

a. Pneumothorax, spontaneous.

(1) Class 1. A history of spontaneous pneumothorax.

(2) Classes 2/2F/3.

(a) Single instance of spontaneous pneumothorax within the last 2 months, and until clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and with no additional lung pathology, or other contraindication to flying.

(b) Recurrent spontaneous pneumothorax; waiver may be considered if effectively treated by pleuridesis and/or pleurectomy with complete recovery and successful completion of an altitude chamber ride to 18,000 feet.

b. Pneumothorax, traumatic, as outlined in *a* (2)(*a)* above.

c. Pulmonary tuberculosis or tuberculous pleurisy; except chemoprophylaxis for tuberculin test conversion only is not disqualifying.

d. Presence of bullae.

e. Sarcoidosis. (See APL, Sarcoidosis.)

4–19. Mouth

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraph 2–24, plus the following:

a. Any infectious lesion until recovery is complete and the part is functionally normal.

b. Any congenital or acquired lesion that interferes with the function of the mouth or throat.

c. Any defect in speech that would prevent or interfere with clear and effective communication in the English language over a radio communication system.

d. Recurrent calculi of any salivary gland or duct.

4–20. Nose

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are in paragraph 2–25, plus the following:

a. History of allergic rhinitis or vasomotor rhinitis requiring the use of antihistamines for a cumulative period greater than 30 days per year. (See APL, Allergic/Non-allergic Rhinitis.)

b. Deviation of the nasal septum or septal spurs that results in symptomatic obstruction of airflow, chronic rhinitis, chronic sinusitis, or interference of sinus drainage.

c. History of nasal polyps, or sinus polyps, or retention cysts.

d. Acute, recurrent sinusitis or chronic sinusitis and/or surgery to treat chronic sinusitis.

4–21. Pharynx, larynx, trachea, and esophagus

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are in paragraph 2–25, plus the following:

a. History of recurrent hoarseness interfering with communication.

b. History of tracheostomy.

c. History of chronic or recurrent eustachian tube dysfunction.

4–22. Neurological disorders

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are in paragraphs 2–26, 2–29*d*, and 4–14, plus the following (see table 4–2):

a. History of electroencephalographic abnormalities of any kind; to include spike–wave complexes, spikes, or sharp waves.

b. History of chronic, recurrent, or incapacitating headaches. (See APL, Headache and Migraine.)

c. History of neuritis, neuralgia, neuropathy, or radiculopathy until reviewed by the USAAMA.

d. History of decompression sickness (Type II) or an air embolism with neurologic involvement.

e. History of disturbances in consciousness, single episode or recurrent; to include nontraumatic loss of consciousness, narcolepsy, cataplexy, all forms of paroxysmal convulsive disorders, or single convulsive seizures of any type, except—

(1) Single episode of documented vasovagal syncope such as syncope with venipuncture or immunizations.

(2) Single episode of documented postural or parade-rest syncope, not otherwise disqualifying.

(3) Febrile seizures before the age of 5 with a normal EEG.

f. Central nervous system infections.

(1) Class 1. Within 1 year prior to examination, except 6 years for encephalitis, or if there are residual neurological deficits or other sequelae.

(2) Classes 2/2F/3. Until complete recovery without residual neurological deficits or other sequelae.

g. History of organic mental syndromes; developmental, learning, or sensory processing disorders; or toxic or metabolic central nervous system disorders, until reviewed by the USAAMA.

h. History of intracranial embolism, vascular insufficiency, thrombosis, hemorrhage, arteriovenous malformation, or aneurysm.

i. History of degenerative or demyelinating process, such as multiple sclerosis, dementia, Alzheimer's disease, Parkinson's disease, or basal ganglia disease.

j. For Class 1, history of diseases with neurologic sequelae, such as hepatolenticular degeneration, neurofibromatosis, acute intermittent porphyria, or familial periodic paralysis.

k. History of benign or malignant neoplasms of the brain, pituitary gland, spinal cord, or their coverings.

l. History of diagnostic or therapeutic craniotomy, or any procedure involving penetration of the dura mater or the brain substance, including ventriculo-peritoneal shunts, evacuation of hematomas, and brain biopsy.

m. Any defect in the bony substance of the skull, regardless of cause.

n. History of any head injury associated with the following will be cause for permanent disqualification for aviation duty for all Classes. (See also table 4–2.)

(1) Intracranial hemorrhage or hematoma, to include epidural, subdural, intracerebral, or subarachnoid hemorrhage.

(2) Any penetration of the dura mater or brain substance.

(3) Radiographic or other evidence of retained intracranial foreign bodies or bony fragments.

(4) Transient or persistent neurological deficits indicative of parenchymal central nervous system injury, such as hemiparesis or cranial neuropathy.

(5) Persistent focal or diffuse abnormalities of the EEG reasonably assumed to be a result of an accident.

(6) Depressed skull fracture with or without dural penetration.

(7) Linear or basilar skull fracture with or without dural penetration.

(8) Posttraumatic syndrome as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium that does not resolve within 6 weeks after injury.

(9) Unconsciousness exceeding 24 hours.

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

o. History of head injury associated with any of the following will be cause for permanent disqualification for flying duties for Class 1; and termination of aviation service for a minimum of 2 years for Classes 2/2F/3. (See table 4–2.)

(1) Linear or basilar skull fracture with loss of consciousness for more than 15 minutes but less than 2 hours.

(2) Posttraumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, that persists for more than 2 weeks, but resolves within 6 weeks of the injury.

(3) Amnesia (posttraumatic and retrograde, patchy or complete), delirium, disorientation, or impairment of judgment that exceeds 24 hours.

(4) Unconsciousness for a period of greater than 2 hours, but less than 24 hours.

p. History of head injury associated with any of the following will be cause for a 2-year disqualification for Class 1; and temporary medical suspension from aviation duty for 3 months for Classes 2/2F/3. (See table 4–2.)

(1) Linear or basilar skull fracture with loss of consciousness for less than 15 minutes.

(2) Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, that persists for more than 48 hours but resolves within 14 days of the injury.

(3) Post-traumatic headaches alone that persist more than 14 days after injury, but resolve within 1 month.

(4) Amnesia (post-traumatic and retrograde, patchy and complete), delirium, or disorientation that lasts less than 24 hours, but more than 12 hours after injury.

(5) Unconsciousness for more than 15 minutes but less than 2 hours.

(6) Cerebrospinal fluid rhinorrhea or otorrhea that clears within 7 days of injury, provided there is no evidence of cranial nerve palsy.

q. History of head injury associated with any of the following will be cause for a 3-month disqualification for Class 1, and temporary medical suspension from aviation duty for 1 month for Classes 2/2F/3.

(1) Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches, or disturbances of equilibrium, that resolves within 48 hours of the injury.

(2) Post-traumatic headaches alone that resolves within 14 days after injury.

(3) Amnesia (post-traumatic and retrograde, patchy and complete), delirium, or disorientation that lasts less than 12 hours after injury.

(4) Unconsciousness less than 15 minutes.

4–23. Mental disorders

The minimum psychiatric evaluation will include Axis I, II, and III, using diagnostic criteria and terms found in DSM–IV. The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraph 2–27, except as modified by the following:

a. History of any psychotic episode evidenced by impairment in reality testing, to include transient disorders, from any cause except transient delirium secondary to toxic or infectious processes before age 12.

b. History of mood disorder, to include major mood disorders, depression, cyclothymic, dysthymic, and mood disorders not otherwise specified.

c. History of anxiety disorder, somatoform disorder, or dissociative disorder, including but not limited to those disorders previously described as neurotic. History of any phobias or severe or prolonged anxiety episodes, after age 12, even if they do not meet the diagnostic criteria of DSM–IV.

d. History of factitious disorders and disorders of impulse control not elsewhere classified.

e. History of pervasive or specific developmental disorders usually first seen in childhood. Stuttering, sleepwalking, and sleep terror disorders if occurring after the 14th birthday.

f. History of personality or behavior disorder. Personality traits insufficient to meet DSM–IV criteria for personality disorder diagnosis may be cause for an unsatisfactory Aeromedical Adaptability (AA) rating (formerly Adaptability Rating for Military Aeronautics (ARMA)). (See para 4–29.)

g. History of any adjustment disorder until reviewed by the USAAMA.

h. Excessive alcohol use.

(1) History of alcohol abuse or dependence by DSM–IV criteria is disqualifying for all Classes.

(2) History of alcohol misuse may be disqualifying for all Classes. (See APL, Alcohol-Related Disorders, for aeromedical evaluation, treatment, and disposition guidelines. See also AR 600–85.)

i. Drug misuse, abuse, or dependence. History of misuse or abuse of any controlled substance, and/or use of any illicit drugs, including marijuana and psychoactive substances for all Classes. (See APL, History of Illicit Drug Use and para 2–31 also applies.)

j. History of suicide attempt or gesture at any time.

k. Insomnia, severe or prolonged.

l. Unconscious (neurotic) fear of flying manifested as psychiatric or somatic symptoms. Refer aircrew with a conscious fear of flying, that is, those who have made a conscious choice not to fly, to the aviation unit commander for a nonmedical disqualification and flying evaluation board (FEB). (See AR 600–105.)

m. Emotional responses to situations of stress, either combat or noncombat, when such a reaction may interfere with the efficient and safe performance of an individual's flying duties as determined by review by the USAAMA.

Note. (See APL, Mental Health Findings.)

4–24. Skin and cellular tissues

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes listed in paragraph 2–28, plus any skin condition that interferes with the use of aviation clothing or life support equipment.

4–25. Spine, scapula, ribs, and sacroiliac joints

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes listed in paragraphs 2–11 and 2–29, plus the following:

a. History of chronic or recurrent disabling episodes of back pain, especially when associated with significant objective findings.

b. History of any fracture or dislocation of the vertebrae, to include insertion of spinal orthopedic hardware. A compression fracture involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 12 months ago and is asymptomatic; except any degree of compression fracture of the cervical vertebrae, twelfth thoracic

vertebrae, or first lumbar vertebra. A history of fracture of the transverse or spinous process is not disqualifying if asymptomatic.

c. Scoliosis.

(1) *Class 1*. Any degree of scoliosis. Scoliosis may be qualified if the angulation is found to be stable by two standing scoliosis x-ray series done 12 months apart, and the scoliosis angle in the thoracic or lumbar spine is 20 degrees or less by the Cobb method.

(2) *Classes 2/2F/3*. Standing scoliosis x-ray series demonstrating an angle in the thoracic or lumbar spine that exceeds 20 degrees by the Cobb method.

4–26. Systemic diseases

The causes for medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes in paragraph 2–30 and 2–32, plus the following: Diseases and conditions that, based upon sound aeromedical principles, may in any way affect or compromise the individual's health or well-being, flying safety, or mission completion. The local flight surgeon will make the initial determination and recommendations to the individuals' commander. The USAAMA will make the final determination of medical unfitness for flying duty.

4–27. Malignant diseases and tumors

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes listed below:

a. Benign tumors, same as the causes listed in paragraphs 2–31*a* and 4–22*k*.

b. History of any malignant tumor, except for basal cell carcinoma of the skin that has been removed. (See also APL, Cancer in Aircrew.)

4–28. Sexually transmitted diseases

The causes of medical unfitness for flying duty Classes 1/2/2F/3/4 are the causes listed in paragraph 2–14*ab*.

4–29. Aeromedical adaptability

a. The cause of medical unfitness for flying duty for all Classes excluding civilian ATCs is an unsatisfactory AA (formerly ARMA) due to socio-behavioral factors that are considered unsuitable for or unadaptable to Army aeronautics. The unsatisfactory AA may be a manifestation of underlying psychiatric disease (see para 4–23) or may be accompanied by non-medical disqualifications. (See AR 600–105.) The unsatisfactory AA is not a diagnosis, but is a determination by the FS and aviation commander or supervisor of suitability or adaptability. An unsatisfactory AA may be revealed by interview, records review, command referral, security investigations, or other documented sources.

b. Until reviewed by the USAAMA, an unsatisfactory AA may exist if any of the conditions listed below are present. Trained aircrew with an unsatisfactory AA should also be referred to the aviation unit commander for administrative evaluation of nonmedical disqualifications and determination of fitness to retain the aircrew member's aeronautical rating or status. (See AR 600–105.) Psychological and psychiatric consultation will be obtained as required by the FS or the USAAMA. The aviation commander and FS will forward their evaluations and recommendations to the USAAMA to make a final recommendation of medical fitness for flying duties. The USAAMA will coordinate with the Chief, Army Aviation Branch, and aeromedical waiver authorities as required. When there is a question of observer bias or loss of objectivity, the USAAMA may obtain additional medical evaluations from other impartial FSs or medical consultants.

(1) Deliberate or willful concealment of significant and/or disqualifying medical conditions on medical history forms or during FS interview.

(2) An attitude toward flying that is clearly less than optimal; for example, the person appears to be motivated overwhelmingly by the prestige, pay, or other secondary gains rather than the skill, achievement, and professionalism of flying itself.

(3) Clearly noticeable personality traits such as immaturity, self-isolation, difficulty with authority, poor interpersonal relationships, impaired impulse control, or other traits that may interfere with group functioning as a team member in an operational aviation setting, even though there are insufficient criteria for a personality disorder diagnosis.

(4) Review of the history or medical records reveals multiple or recurring physical complaints that strongly suggest either a somatization disorder or a propensity for physical symptoms during times of stress. (See also para 4–23*m*.)

(5) A history of arrests, illicit drug use, or social "acting out" that may indicate immaturity, impulsiveness, or antisocial traits. Experimental use of drugs during adolescence, minor traffic violations, or clearly provoked impulsive episodes may be found fit after review by the USAAMA. (See also para 4–23*i*.)

(6) Significant prolonged or currently unresolved interpersonal or family problems, marital dysfunction, or significant family opposition or conflict concerning the Soldier's aviation career.

c. Until reviewed by the USAAMA, an unsatisfactory AA may be given for lower levels (symptoms and signs) than those mentioned in *b*above if, in the opinion of the FS and aviation commander or civilian supervisor, mental or physical factors might be exacerbated under the stresses of Army aviation or the person might not be able to carry out his or her duties in a mature and responsible fashion. A person may be disqualified for any of a combination of factors listed in *b*above and/or due to personal habits or appearance indicative of attitudes of carelessness, poor motivation, or other characteristics that may be unsafe or undesirable in the aviation environment.

4–30. Reading Aloud Test

The cause of medical unfitness for flying duty Classes 1/2/2F/3/4 is failure to clearly communicate in the English language in a manner compatible with safe and effective aviation operations. For initial applicants, this is determined by administration of the Reading Aloud Test. (See ATB 2, Army Flight Surgeon's Administrative Guide.) In questionable cases, the aviation unit commander, ATC supervisor, or other appropriate aviation official will provide a written recommendation to the FS.

4–31. Department of the Army civilian and contract civilian aircrew members

a. The following references apply as noted.

(1) 5 CFR Part 339, Office of Personnel Management, applies to DA civilians.

(2) AR 95–20/AFJI 10–220/NAVAIRINST 3710.1E/DCMA INST 8210.1 applies to contract civilian aircrew members who fly in aircraft owned or leased by DOD.

(3) 14 CFR Part 61 and 14 CFR Part 67, Federal Aviation Administration, do not apply since Army civilian aircrew members fly public use aircraft. The agency that owns or operates public use aircraft is responsible for the medical certification of aircrew flying those aircraft.

b. The aeromedical certification of civilian aircrew members has three major components:

(1) *Examination method.* The Army determines the scope of examination and the examiners as outlined in chapter 6, APLs, and ATBs.

(2) *Aeromedical standard.* The classes of medical standards for flying are listed in paragraph 4–2. The medical conditions that pertain to each specific medical standard for flying are contained in paragraphs 4–4 through 4–33.

(3) *Aeromedical disposition.* The Army makes the final determination of fitness for flying duties using the administrative procedures in chapter 6, APLs, and ATBs. The Army may require additional consultations, examinations, and tests before a final determination is made. Civilian aircrew members may submit other medical documents from health care providers of their choice. The USAAMA may consult DA-designated aeromedical consultants and the Army Aeromedical Consultant Advisory Panel (ACAP) as required. The USAAMA makes the final recommendation of aeromedical fitness to the civilian aircrew member waiver authority designated in paragraphs 6–21*e* and 6–21*f*. The recommendation considers the civilian aircrew member's medical condition, aircraft flown, mission and duties and deployability status. The recommendation may be qualified, disqualified with waiver, or medical termination from aviation service. The waiver authority grants or denies the aeromedical recommendation.

(a) DAC aircrew members granted medical termination from aviation service are referred by the supervisor aviation unit commander to the Civilian Personnel Office for assistance in reassignment to duties not to include flying (DNIF). The Office of Personnel Management makes the final determination of eligibility for medical disability.

(b) Contract civilian aircrew members granted medical termination from aviation service are referred by the Contracting Officer Representative to the contractor management for reassignment to DNIF or termination of employment.

c. The following exception applies to civilian aircrew members. Civilian aircrew members are not required to meet the requirements of the Army Weight Control Program (AR 600–9). However, maximal allowable weight and anthropometric measurements are necessary and shall be followed to permit normal function required for safe and effective aircraft flight without interfering with aircraft instruments or controls, aircraft egress, or proper function of crash worthy or ejection seat systems. (See para 4–33 for ATC personnel.)

4–32. Medical standards for Class 3 personnel

a. Initial and subsequent medical certification of Class 3 aircrew is conducted according to this regulation, and APLs and ATBs issued by the USAAMA.

b. The attending FS/APA/AMNP/AME makes the initial determination of fitness for Class 3 flying duties.

c. The FS/APA/AMNP/AME will utilize the following guidelines for Class 3 waiver/suspension recommendations:

(1) Class 3 aircrew with a major physical or psychological disqualification will be recommended for suspension from flying duties. Other disqualifications may be waived for flying duties. The FS/APA/AMNP/AME will take into consideration the operational duties and responsibilities of Class 3 aircrew before recommending a waiver/suspension action to the aviation unit commander. Questionable cases will be referred to the USAAMA.

(2) A major physical or psychological defect in the operational aviation environment is defined as any defect that will—

(a) Interfere with duties requiring visual or auditory acuity, speech clarity, dexterity, or adequate range of motion.

(b) Interfere with wearing aviation life support equipment, or use of controls at their duty station.

(c) Reduce the ability to withstand rapid changes in atmospheric pressure or forces of acceleration.

(d) Increase the risk of sudden incapacitation, compromising personal health, aviation safety, mission completion, or deployability.

(e) Require medications or treatments that compromise flight safety or deployability.

(3) Alcohol/drug abuse or dependence requires AHRC or NGB waiver.

d. The local aviation unit commander or civilian waiver authority, as appropriate, will grant or deny the aeromedical recommendation for waiver or suspension.

4–33. Medical standards for ATC personnel

a. *DAC and DA contract civilian ATCs.*

(1) Medical qualification requirements for Department of the Army civilian Air Traffic Controllers are outlined in Office of Personnel Management Operating Manual: Qualification Standards for General Schedule Positions, GS–2152: Air Traffic Control Series, in accordance with Section 339.202, Title 5, Code of Federal Regulations.

(2) DA contract civilian ATCs may be required by their contractor employer to maintain a Class II Federal Aviation Administration (FAA) medical certification; but this certification is not required by DA or FAA for contract ATCs to control air traffic in DOD facilities (14 CFR 65.31, 33). The initial and subsequent determinations of medical fitness for ATC duties are made as outlined in this regulation. The contract will state that DA contract ATCs will meet the same medical qualification requirements as those for DA civilians set forth in (1) above.

b. *Class 4 military ATCs.* The causes for unfitness for Class 4 ATC duties are—

(1) Eye. (See paras 4–11 and 4–12.)

(2) Ear, nose, and throat. (See also para 4–7.)

(a) Unilateral or bilateral disease of the outer, middle, or inner ear that may interfere with the comfortable, efficient use of the standard headphone apparatus, with accurate perception of voice transmissions or spoken communications, or equilibrium.

(b) Disease or malformation of the mouth or throat that may interfere with enunciation and clear speech, to include stuttering or stammering. (See paras 4–6, 4–19, and 4–30.)

(c) Hearing loss that exceeds the standards in table 4–1.

(d) Nose and sinuses. (See para 4–20.)

(3) Cardiovascular and blood pressure. (See para 4–15.)

(4) Neuropsychiatric. (See paras 4–22, 4–23, and 4–29.)

(5) Endocrine. (See para 4–9 and APL, Diabetes and Glucose Intolerance.)

(6) Musculoskeletal.

(a) Any deformity or condition of the spine or limbs, or absence of any extremity, digit, or any portion thereof, that may interfere with satisfactory and safe performance of duty.

(b) Any condition that predisposes to fatigue or discomfort induced by long periods of standing or sitting.

(7) Weight and body build. These factors must not interfere with the operation of ATC equipment, or the use of work place facilities such as office chair or staircase.

(8) HIV seropositivity. (Civilian employees: Normally, neither applicants for employment nor current employees may be required to be tested for the presence of the HIV antibody. Civilian employees are not disqualified based solely on the presence of the HIV virus. See AR 600–110 and ATB 2, Army Flight Surgeon's Administrative Guide.)

(9) Other medical conditions. Other organic, systemic, functional, or structural diseases, defects, or limitations that in the opinion of the attending FS may be a potential hazard to safety in the Air Traffic Control System, or predispose to sudden incapacitation or inability to adapt to stress. (See paras 4–26, 4–27, and 4–28.) A pertinent history and clinical evaluation including laboratory screening will be obtained, and when clinically indicated, special consultations and examinations will be accomplished and forwarded to the USAAMA for review.

(10) Medications. Unfitting for ATC duties and requires a waiver. (See APL, Medications.)

Table 4–1
Acceptable audiometric hearing level for Army aviation and air traffic control

ISO 1964–ANSI 1996 (unaided sensitivity)						
Frequency (HZ)	500	1000	2000	3000	4000	6000
Class 1	25	25	25	35	45	45
Classes 2/2F/3/4	25	25	25	35	55	65

Table 4–2
Head injury guidelines for Army aviation

Disposition by Class (Refer to the glossary for acronyms and abbreviations used)				
Class 1	Perm DQ	Perm DQ	2-year DQ	3-month DQ
Classes 2/2F/3/4	Perm DQ	2-year DQ	3-month DQ	4-week DQ
Problem:				
– Intracranial bleeding	Any	——	——	——
– Penetration of dura or brain	Any	——	——	——
– Intracranial bone fragment or foreign bodies	Any	——	——	——
– Central nervous system deficits indicating parenchymal injury	Any	——	——	——
– EEG abnormality due to injury	Any	——	——	——
– Depressed skull fracture	Any	——	——	——
– Basilar or linear skull fracture with–	LOC > 2h	LOC 15m–2h	LOC <15m	——
– Post trauma syndrome lasting–	>6wk	2wk–6wk	48h–14d	<48h
– Loss of consciousness lasting–	>24h	2–24h	15m–2h	<15m
– Cerebrospinal fluid leaking–	>7d	——	<7d	——
– Amnesia, delirium, or disorientation lasting–	——	>24h	12–24h	<12h

Note:

[1] DQ: (aeromedical disqualification.

[2] LOC: loss of consciousness.

Chapter 5
Medical Fitness Standards for Miscellaneous Purposes

5–1. General
This chapter sets forth medical conditions and physical defects that are causes for rejection for—

a. Airborne training and duty, Ranger training and duty, and Special Forces training and duty.
b. SERE training.
c. Freefall parachute training and duty.
d. Army service schools.
e. Diving training and duty.
f. Enlisted MOSs.
g. Geographical area assignments.
h. Deployment.

5–2. Application
The standards apply to applicants or individuals from all COMPOS under consideration for selection or retention in these programs, assignments, or duties.

5–3. Medical fitness standards for initial selection for Airborne training, Ranger training, and Special Forces training, and Reconnaissance and Surveillance Leaders Course training
The causes of medical unfitness for initial selection for Airborne training, Ranger training, Special Forces, and Reconnaissance and Surveillance Leaders Course (RSLC) training are all the causes listed in chapter 2, plus all the causes listed in paragraphs 5–3 and 5–4.

a. Abdomen and gastrointestinal system.
(1) Paragraph 2–3.
(2) Hernia of any variety including inguinal and other abdominal.
(3) Operation for relief of intestinal adhesions at any time.
(4) Laparotomy within a 6-month period.
(5) Chronic or recurrent gastrointestinal disorder.
(6) For Special Forces initial training, asplenia (absence of the spleen) for any reason.
b. Blood and blood–forming tissue diseases.
(1) Paragraph 2–4.
(2) Sickle cell disease.
c. *Dental*. Paragraph 2–5.

d. Ears and hearing.
(1) Paragraphs 2–6 and 2–7.
(2) Radical mastoidectomy.
(3) Any infectious process of the ear until completely healed.
(4) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of the Eustachian tube.
(5) Recurrent or persistent tinnitus.
(6) History of attacks of vertigo, with or without nausea, emesis, deafness, or tinnitus.
e. Endocrine and metabolic diseases. Paragraph 2–8.
f. Extremities.
(1) Paragraphs 2–9 through 2–11.
(2) Less than full strength and range of motion of all joints.
(3) Loss of any digit from either hand.
(4) Deformity or pain from an old fracture.
(5) Instability of any degree of major joints.
(6) Poor grasping power in either hand.
(7) Locking of a knee joint at any time.
(8) Pain in a weight–bearing joint.
(9) Retained hardware that is integral to maintaining fixation or stability, or presents a risk to mobility or a risk of further injury by its presence.
g. Eyes and vision.
(1) Paragraphs 2–12 and 2–13 with exceptions noted below.
(2) For Airborne and Ranger training: Distant visual acuity of any degree that does not correct to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.
(3) For Special Forces training: Distant visual acuity of any degree that does not correct to 20/20 in both eyes with spectacle lenses. Any refractive error in spherical equivalent of worse than plus or minus 8 diopters.
(4) For Airborne and Special Forces training: Failure to pass the PIP set or FALANT test for color vision (see para 4–2*a)* unless the applicant is able to identify vivid red and/or vivid green as projected by the Ophthalmological Projector or the Stereoscope, Vision Testing (SVT).
h. *Genitourinary system.* Paragraphs 2–14 and 2–15.
i. Head and neck.
(1) Paragraphs 2–16 and 2–17.
(2) Loss of bony substance of the skull.
(3) Persistent neuralgia; tic douloureux; facial paralysis.
(4) A history of subarachnoid hemorrhage.
j. *Heart and vascular system.* Paragraphs 2–18 through 2–19, except for Special Forces training and duty: blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of less than 60 mmHG or greater than 90 mmHg, regardless of age. Unsatisfactory orthostatic tolerance test is also disqualifying.
k. *Height.* No special requirement.
l. *Weight.* No special requirement.
m. *Body build.* Paragraph 2–22.
n. Lungs and chest wall.
(1) Paragraph 2–23.
(2) Spontaneous pneumothorax, except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and no additional lung pathology or other contraindication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.
o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2–24 through 2–25.
p. Neurological disorders.
(1) Paragraph 2–26.
(2) Active disease of the nervous system of any type.
(3) Craniocerebral injury (see para 4–22*m)*.
(4) Abnormal emotional responses to situations of stress (both combat and noncombat), when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of the Soldier's duties.
q. Mental disorders.
(1) Paragraph 2–27.

(2) Individuals who are under treatment with any mood-ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, and so forth, and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness, or emotional instability. Fear of dark or enclosed spaces, fear of heights.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias that materially influence behavior.

(7) Abnormal emotional response to situations of stress, when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

r. Skin and cellular tissues. Paragraph 2–28.

s. Spine, scapulae, and sacroiliac joints.

(1) Paragraph 2–29.

(2) Scoliosis: lateral deviation of tips of vertebral spinous processes more than an inch.

(3) Spondylolysis; spondylolisthesis.

(4) Healed fractures or dislocations of the vertebrae.

(5) Lumbosacral or sacroiliac strain, or any history of a disabling episode of back pain, especially when associated with significant objective findings.

t. Systemic disease, general and miscellaneous conditions and defects.

(1) Paragraphs 2–30 and 2–32.

(2) Chronic motion sickness.

(3) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs and for a period of 4 weeks after the drug has been discontinued.

(4) Any severe illness, operation, injury, or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual.

u. Tumors and malignant disease. Paragraph 2–31.

v. Sexually transmitted diseases. Paragraph 2–30.

5–4. Medical fitness standards for selection for survival, evasion, resistance, escape training

The causes of medical unfitness for SERE training are all the causes listed in chapter 3, plus all the causes listed in this paragraph.

a. Abdomen and gastrointestinal system. Paragraphs 2–3 and 3–5.

b. Blood and blood–forming tissue diseases. Paragraphs 3–7 and 3–42.

c. *Dental.* Paragraph 3–8.

d. *Ears and hearing.* Paragraphs 2–6, 2–7, 3–9, and 3–10.

e. *Endocrine and metabolic diseases.* Paragraphs 2–8*b*, 2–8*c*, 2–8*h*, 2–8*j*, and 3–11.

f. *Extremities.* Paragraphs 2–9*b*(8), 2–10*b*(3), 2–10*b*(6), 2–11*c*, 2–11*d*(2), 2–11*e*, and 3–12 through 3–14.

g. *Eyes and vision.* Paragraphs 3–15 and 3–16.

h. *Genitourinary system.* Paragraphs 2–14, 2–15, and 2–36.

i. Head and neck. Paragraph 5–3*i*.

j. *Heart and vascular system.* Paragraphs 2–18 and 2–19.

k. *Height.* No special requirements.

l. *Weight.* No special requirements.

m. *Body build.* Paragraph 2–22.

n. Lungs and chest wall. Paragraph 2–23.

o. Mouth, nose, pharynx, larynx, trachea and esophagus. Paragraphs 2–24 and 2–25.

p. Neurological disorders.

(1) Paragraphs 2–26 and 4–22.

(2) Active disease of the nervous system of any type.

q. Mental disorders.

(1) Paragraph 2–27.

(2) Evidence of excessive anxiety, tenseness, or emotional responses to situations of stress (both combat and noncombat), when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of the Soldier's duties.

r. Skin and cellular tissues. Paragraph 2–28.

s. Spine, scapulae, and sacroiliac joints. Paragraph 2–29.

t. Systemic disease and miscellaneous conditions and defects.

(1) Paragraphs 2–30 and 2–32.

(2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs and for a period of 4 weeks after the drug has been discontinued.

(3) Any severe illness, operation, injury, or defect of such a nature or of recent occurrence as to constitute an undue hazard to the individual.

u. Tumors and malignant diseases. Paragraph 2–31.

v. Sexually transmitted diseases. Paragraph 2–30.

5–5. Medical fitness standards for retention for Airborne duty, Ranger duty, and Special Forces duty

Retention of an individual in Airborne duty, Ranger duty, and Special Forces duty will be based on—

a. His or her continued demonstrated ability to perform satisfactorily his or her duty as an Airborne officer or enlisted Soldier, Ranger, or Special Forces member.

b. The effect upon the individual's health and well-being by remaining on Airborne, Ranger, or Special Forces duty.

5–6. Medical fitness standards for initial selection for free fall parachute training

The causes of medical unfitness for initial selection for free fall parachute training are the causes listed in chapter 2 plus the causes listed in this paragraph and in paragraph 5–3.

a. Abdomen and gastrointestinal system. Paragraph 2–3.

b. Blood and blood–forming tissue diseases.

(1) Paragraph 2–4.

(2) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

(3) Sickle cell disease.

(4) Sickle cell trait if the hemoglobin is less than 12.0g./dl., or there is any history of vasoocclusive crises.

c. Dental.

(1) Paragraph 2–5.

(2) Any unserviceable teeth until corrected.

d. Ears and hearing.

(1) Paragraphs 2–6 and 2–7.

(2) Abnormal labyrinthine function.

(3) Any infectious process of the ear, including external otitis, until completely healed.

(4) History of attacks of vertigo with or without nausea, emesis, deafness, or tinnitus.

(5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of the Eustachian tube.

(6) Perforation, marked scarring, or thickening of the ear drum.

e. Endocrine and metabolic diseases. Paragraph 2–8.

f. Extremities.

(1) Paragraphs 2–9 through 2–11.

(2) Any limitation of motion of any joint that might compromise safety.

(3) Any loss of strength that might compromise safety.

(4) Instability of any degree or pain in a weight–bearing joint.

(5) Retained hardware that is integral to maintaining fixation or stability, or presents a risk to mobility or a risk of further injury by its presence.

g. Eyes and vision.

(1) Paragraphs 2–12 and 2–13, with exceptions noted in (2) and (3) below.

(2) Uncorrected near visual acuity (14 inches) of worse than 20/50 in the better eye. Uncorrected distant visual acuity of worse than 20/100 in either eye. Distant vision that does not correct to 20/20 in both eyes with spectacle lenses. Any refractive error worse than plus or minus 8 diopters.

(3) Failure to pass the PIP or FALANT test for color vision unless the applicant is able to identify vivid red and vivid green as projected by the Ophthalmological Projector or the SVT.

(4) Any history of Laser-Assisted in situ Keratomileusis (LASIK) surgery is disqualifying.

h. *Genitourinary system.* Paragraphs 2–14 and 2–15.

i. Head and neck.

(1) Paragraphs 2–16 and 2–17.

(2) Loss of bony substance of the skull if retention of personal protective equipment is affected.

(3) A history of subarachnoid hemorrhage.

j. *Heart and vascular system.* Paragraphs 2–18 and 2–19, except blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of less than 60 mmHg or greater than 90 mmHg regardless of age. An unsatisfactory orthostatic tolerance test is also disqualifying.

k. *Height.* Paragraph 2–20.

l. *Weight.* Paragraph 2–21.

m. *Body build.* Paragraph 2–22.

n. Lungs and chest wall.

(1) Paragraph 2–23.

(2) Congenital or acquired defects that restrict pulmonary function, cause air-trapping, or affect ventilation-perfusion.

(3) Spontaneous pneumothorax, except a single occurrence at least 3 years before the date of the examination with clinical evaluation showing complete recovery with normal pulmonary function.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2–24 and 2–25.

p. Neurological disorders.

(1) Paragraphs 2–26.

(2) The criteria outlined in paragraph 4–22 for Classes 2 and 3 flying duty apply.

q. Mental disorders.

(1) Paragraph 2–27.

(2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness, or emotional instability.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias that materially influence behavior.

(7) Abnormal emotional response to situations of stress, when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

r. Skin and cellular tissues. Paragraph 2–28.

s. Spine, scapulae, ribs, and sacroiliac joints.

(1) Paragraph 2–29.

(2) Spondylolysis; spondylolisthesis.

(3) Healed fracture or dislocation of the vertebrae except mild, asymptomatic compression fracture.

(4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

t. Systemic disease, general and miscellaneous conditions and defects.

(1) Paragraphs 2–30 and 2–32.

(2) History of motion sickness, other than isolated instances without emotional involvement.

(3) Any severe illness, operation, injury, or defect of such a nature or of so recent an occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

u. Tumors and malignant diseases. Paragraph 2–31.

v. Sexually transmitted diseases. Paragraph 2–30.

5–7. Medical fitness standards for retention for free fall parachute duty

Retention of an individual in free fall parachute duty will be based on—

a. The Soldier's demonstrated ability to satisfactorily perform free fall parachute duty.

b. The effect upon the individual's health and well-being by remaining on free fall parachute duty.

c. Determination of whether of any severe illness, operation, injury, or defect is of such a nature or of such recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

5–8. Medical fitness standards for Army service schools

Except as provided elsewhere in this regulation, medical fitness standards for Army service schools are covered in other various Army Regulations.

5–9. Medical fitness standards for initial selection for marine diving training (Special Forces and Ranger combat diving)

The causes of medical unfitness for initial selection for marine self-contained underwater breathing apparatus (SCUBA) diving training are the causes listed in chapter 2, plus the following:

a. Abdomen and gastrointestinal system. Paragraph 2–3.

b. Blood and blood–forming tissue diseases.

(1) Paragraph 2–4.

(2) Significant anemia or history of hemolytic disease due to variant HGB state.

(3) Sickle cell disease.

c. Dental.

(1) Paragraph 2–5.

(2) Any infectious process and any conditions that contribute to recurrence until eradicated.

(3) Edentia; any unserviceable teeth until corrected.

(4) Moderate malocclusion extensive restoration or replacement by bridges or dentures that interfere with the use of SCUBA. Residual teeth and fixed appliances must be sufficient to allow the individual to easily retain a SCUBA mouthpiece.

d. Ears and hearing.

(1) Paragraphs 2–6 and 2–7.

(2) Persistent or recurrent abnormal labyrinthine function as determined by appropriate tests.

(3) Any infectious process of the ear, including external otitis, until completely healed.

(4) History of attacks of vertigo with or without nausea, emesis, deafness, or tinnitus.

(5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of Eustachian tube. (See pressure test requirement in *w*, below.)

(6) Perforation, marked scarring, or thickening of the eardrum.

e. Endocrine and metabolic diseases. Paragraph 2–8.

f. Extremities.

(1) Paragraphs 2–9 through 2–11.

(2) Any limitation of motion of any joint that might compromise safety.

(3) Any loss of strength that might compromise safety.

(4) Instability of any degree or pain in a weight-bearing joint.

(5) History of osteonecrosis (aseptic necrosis of the bone) of any type.

(6) Retained hardware that is integral to maintaining fixation or stability, or presents a risk to mobility, or a risk of further injury by its presence.

g. Eyes and vision.

(1) Paragraphs 2–12 and 2–13, with exceptions noted in (2) and (3), below.

(2) Distant visual acuity that does not correct to 20/20 in both eyes with spectacle lenses. Any refractive error in spherical equivalent of worse than plus or minus 8 diopters.

(3) Failure to pass the PIP set or FALANT test for color vision unless the applicant is able to identify vivid red and/or vivid green as projected by the Ophthalmological Projector or the SVT.

(4) Any history of Laser-Assisted in Situ Keratomileusis (LASIK) surgery is disqualifying.

h. *Genitourinary system.* Paragraphs 2–14 and 2–15.

i. Head and neck.

(1) Paragraphs 2–16 and 2–17.

(2) Loss of bony substance of the skull if retention of personal protective equipment is affected.

(3) History of subarachnoid hemorrhage.

j. *Heart and vascular system.* Paragraphs 2–18 and 2–19, except blood pressure with a preponderant systolic of less than 90 mmHg or greater than 140 mmHg or a preponderant diastolic of less than 60 mmHg or greater than 90 mmHg, regardless of age. An unsatisfactory orthostatic tolerance test is also disqualifying.

k. *Height.* Paragraph 2–20.

l. *Weight.* The individual must meet the weight standards prescribed by AR 600–9. The medical examiner may impose body fat measurements not otherwise requested by the commander.

m. Body build.

(1) Paragraph 2–22.

(2) Obesity of any degree.

n. Lungs and chest wall.

(1) Paragraph 2–23.

(2) Congenital or acquired defects that restrict pulmonary function, cause air-trapping, or affect ventilation or perfusion.

(3) Spontaneous pneumothorax, except a single occurrence at least 3 years before the date of the examination with clinical evaluation showing complete recovery with normal pulmonary function.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2–24 and 2–25.

p. Neurological disorders.

(1) Paragraph 2–26.

(2) The criteria outlined in paragraph 4–22 for Classes 2 and 3 flying duty apply.

q. *Psychotic disorders.* Learning, psychiatric, and behavioral disorders. Disorders with psychotic features, affective disorders (mood disorders), anxiety, somatoform, or dissociative disorders (neurotic disorders).

(1) Paragraph 2–27.

(2) Individuals who are under treatment with any of the mood ameliorating, tranquilizing, or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc, and for a period of 4 weeks after the drug has been discontinued.

(3) Evidence of excessive anxiety, tenseness, or emotional instability.

(4) Fear of flying when a manifestation of a psychiatric illness.

(5) History of psychosis or attempted suicide at any time.

(6) Phobias that materially influence behavior.

(7) Abnormal emotional response to situations of stress, when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

(8) Fear of depths, enclosed places, or of the dark.

r. Skin and cellular tissues. Paragraph 2–28.

s. *Spine, scapulae, ribs, and sacroiliac joints.* (Consultation with an orthopedist and, if available, a diving medical officer (DMO) will be obtained in questionable cases.)

(1) Paragraph 2–29.

(2) Spondylolisthesis; spondylolysis that is symptomatic or likely to interfere with diving duty.

(3) Healed fracture or dislocation of the vertebrae except a mild, asymptomatic compression fracture.

(4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

t. Systemic disease, general and miscellaneous conditions and defects.

(1) Paragraphs 2–30 and 2–32.

(2) Chronic motion sickness.

(3) Any severe illness, operation, injury, or defect of such a nature or of so recent an occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

u. Tumors and malignant diseases. Paragraph 2–31.

v. Sexually transmitted diseases. Paragraph 2–30.

w. *Pressure equalization and oxygen intolerance.* If a hyperbaric chamber is available, examinees will be tested for the following disqualifying condition: Failure to equalize pressure. All candidates will be subjected, in a compression chamber, to a pressure of 27 pounds (12.15 kilogram (60 feet) per square inch to determine their ability to withstand the effects of pressure, to include ability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver. This test should not be performed in the presence of a respiratory infection that may temporarily impair the ability to equalize or ventilate.

5–10. Medical fitness standards for retention for marine diving duty (Special Forces and Ranger combat diving)

Retention of a Soldier in marine diving duty (SCUBA) will be based on—

a. The Soldier's demonstrated ability to satisfactorily perform marine (SCUBA) diving duty.

b. The effect upon the Soldier's health and well being by remaining on marine (SCUBA) diving duty.

c. Determination of whether of any severe illness, operation, injury, or defect is of such a nature or of such recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

5–11. Medical fitness standards for initial selection for other marine diving training (MOS 00B)

The causes of medical unfitness for initial selection for diving training are all of the causes listed in chapter 2, plus the following:

a. Abdomen and gastrointestinal system.

(1) Paragraph 2–3.

(2) Hernia of any variety.

(3) Operation for relief of intestinal adhesions at any time.

(4) Chronic or recurrent gastrointestinal disorder that may interfere with or be aggravated by diving duty. Severe colitis, peptic ulcer disease, pancreatitis, and chronic diarrhea do not meet the standard unless asymptomatic on an unrestricted diet for 24 months with no radiographic or endoscopic evidence of active disease or severe scarring or deformity.

(5) Laparotomy or celiotomy within the preceding 6 months.

b. Blood and blood-forming tissue diseases.

(1) Paragraph 2–4.
(2) Sickle cell disease.
(3) Significant anemia or history of hemolytic disease due to variant HGB state.

c. Dental.
(1) Paragraph 2–5.
(2) Any infectious process and any conditions that contribute to recurrence until eradicated.
(3) Edentia; any unserviceable teeth until corrected.
(4) Moderate malocclusion, extensive restoration, or replacement by bridges or dentures that interferes with the use of SCUBA. Residual teeth and fixed appliances must be sufficient to allow the individual to easily retain a SCUBA mouthpiece.

d. Ears and hearing.
(1) Paragraphs 2–6 and 2–7.
(2) Perforation, marked scarring, or thickening of the eardrum.
(3) Inability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver. See paragraph 5–9*w*.
(4) Acute or chronic disease of the auditory canal, tympanic membrane, middle or internal ear.
(5) Audiometric average level for each ear not more than 25dB at 500, 1000, and 2000 Hz with no individual level greater than 30dB. Not over 45dB at 4000 Hz.
(6) History of otitis media or otitis externa with any residual effects that might interfere with or be aggravated by diving duty.

e. Endocrine and metabolic disease. Paragraph 2–8.

f. Extremities.
(1) Paragraphs 2–9 through 2–11.
(2) History of chronic or recurrent orthopedic pathology that would interfere with diving duty.
(3) Loss of any digit or portion thereof of either hand that significantly interferes with normal diving duty.
(4) Fracture or history of disease or operation involving any major joint until reviewed by a DMO.
(5) Any limitation of strength or range of motion of any of the extremities that would interfere with diving duties.

g. Eyes and vision.
(1) Paragraph 2–12.
(2) Distant visual acuity, uncorrected, 20/200; not correctable to 20/20, each eye.
(3) Near visual acuity, uncorrected, of less than 20/50 or not correctable to 20/20.
(4) Failure to pass the PIP Set or FALANT test for color vision, unless the applicant is able to identify vivid red and vivid green as projected by the Ophthalmological Projector or the SVT.
(5) Abnormalities of any kind noted during ophthalmoscopic examination that significantly affect visual function or indicate serious systemic disease.

h. Genitourinary system.
(1) Paragraphs 2–14 and 2–15.
(2) Chronic or recurrent genitourinary disease or complaints including glomerulonephritis and pyelonephritis.
(3) Abnormal findings by urinalysis, including significant proteinuria and hematuria.
(4) Varicocele, unless small and asymptomatic.

i. *Head and neck.* Paragraphs 2–16, 2–17, and 4–14.

j. Heart and vascular system.
(1) Paragraphs 2–18 and 2–19.
(2) Varicose veins that are symptomatic or may become symptomatic as a result of diving duty; deep vein thrombophlebitis; gross venous insufficiency.
(3) Marked or symptomatic hemorrhoids.
(4) Any circulatory defect (shunts, stasis, and others) resulting in increased risk of decompression sickness.
(5) Persistent tachycardia or arrhythmia except for sinus type.

k. *Height.* Less than 66 or more than 76 inches.

l. *Weight.* Weight related to height that is outside the limits prescribed by AR 600–9.

m. Body build.
(1) Paragraph 2–22.
(2) Even though the Soldier's weight or body composition is within the limits prescribed by AR 600–9, he or she will be found medically unfit if the examiner considers that his or her weight or associated conditions in relationship to the bony structure, musculature, and/or total body fat content would adversely affect diving safety or endanger the Soldier's well–being if permitted to continue in diving status.

n. Lungs and chest wall.

(1) Paragraph 2–23.

(2) Congenital or acquired defects that restrict pulmonary function, cause air trapping, or affect ventilation–perfusion ratio.

(3) Any chronic obstructive or restrictive pulmonary disease at the time of examination.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus.

(1) Paragraphs 2–24 and 2–25.

(2) History of chronic or recurrent sinusitis at any time.

(3) Any nasal or pharyngeal respiratory obstruction.

(4) Chronically diseased tonsils until removed.

(5) Speech impediments of any origin; any condition that interferes with the ability to communicate clearly in the English language.

p. Neurological disorders.

(1) Paragraph 2–26.

(2) The special criteria that are outlined in paragraph 4–22 for Class 1 flying duty are applicable to diving duty.

q. Mental disorders.

(1) Paragraphs 2–27 through 2–31.

(2) The special criteria that are outlined in paragraph 4–23 for Class 1 flying duty are applicable to diving duty.

(3) The Military Diving Adaptability Rating may be considered MDAR satisfactory if the applicant meets the standards of paragraph 4–29 with the addition of having no fear of depths, enclosed places, or of the dark.

r. *Skin and cellular tissues.* Any active or chronic disease of the skin.

s. Spine, scapulae, ribs, and sacroiliac joints.

(1) Paragraph 2–33.

(2) Spondylolysis; spondylolisthesis.

(3) Healed fractures or dislocations of the vertebrae until reviewed by a DMO.

(4) Lumbosacral or sacroiliac strain, or any history of a disabling episode of back pain, especially when associated with significant objective findings.

t. Systemic diseases and miscellaneous conditions and defects.

(1) Paragraphs 2–34 and 2–35.

(2) Any severe illness, operation, injury, or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe diving.

u. Tumors and malignant diseases. Paragraph 2–36.

v. Sexually transmitted diseases.

(1) Active sexually transmitted disease until adequately treated.

(2) History of clinical or serological evidence of active or latent syphilis, unless adequately treated, or of cardiovascular or central nervous system involvement at any time. Serological test for syphilis required.

w. Oxygen intolerance. See paragraph 5–9*w*.

5–12. Medical fitness standards for retention for other marine diving duty (MOS 00B)

The medical fitness standards contained in paragraph 5–11 apply to all personnel performing diving duty except that divers of long experience and a high degree of efficiency must—

a. Be free from disease of the auditory, cardiovascular, respiratory, genitourinary, and gastrointestinal systems.

b. Maintain their ability to equalize air pressure.

c. Have visual acuity, near and far, that corrects to 20/30 in the better eye.

5–13. Asplenic Soldiers

a. Asplenic Soldiers are disqualified from initial training and duty in military specialties involving significant occupational exposure to dogs or cats.

b. Asplenic Soldiers are disqualified from initial Special Forces training.

5–14. Medical fitness standards for deployment and certain geographical areas

a. All Soldiers considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States (CONUS) are medically qualified to serve in similar or corresponding areas outside the continental United States (OCONUS).

b. Because of certain medical conditions, some Soldiers may require administrative consideration when assignment to combat areas or certain geographical areas is contemplated. Such consideration of their medical conditions would ensure

these Soldiers are used within their functional capabilities without undue hazard to their health and well-being as well as ensure they do not produce a hazard to the health or well-being of other Soldiers.

c. Active duty Soldiers who do not meet the medical retention standards in chapter 3 of this regulation must be referred to an MEB/PEB for a fitness-for-duty determination. RC Soldiers not on active duty, who do not meet medical retention standards are referred for a fitness determination in accordance with paragraphs 9–10 (USAR) and 10–26 (NGB). Soldiers (RC or Active Army) with a permanent 3 or 4 in the physical profile who meet or might meet medical retention standards must be referred to an MMRB to determine if they are world-wide deployable (or be granted a waiver according to AR 600–60). However, Soldiers returned to duty by an MMRB or PEB, retained in the RC under paragraphs 9–10 or 10–26, or Soldiers with temporary medical conditions may still have some assignment/deployment limitations that must be considered before a decision is made to deploy.

d. The final decision to deploy a Soldier with certain medical conditions is a command decision, based on the health care provider's (HCP's) recommendations and taking into account the geographical and environmental conditions the Soldier will be subject to and the mission requirements the Soldier will be assigned. A Soldier with a temporary profile may deploy after the temporary disqualification expires or when the commander and the HCP agree the Soldier is deployable. When HCPs and unit commanders disagree on the deployability status of a Soldier, the decision will be raised to the first general officer in the Soldier's chain of command, who will review the case and make the final decision. For Soldiers with conditions listed in current DOD guidance or the combatant command's (COCOM's) published medical screening criteria, the general officer recommending deployment must submit a waiver request through the COCOM surgeon to the combatant commander for approval. If the Soldier has a temporary profile, it should be determined that the profile complies with the time limitations (including extensions) of AR 40–501. Soldiers with a permanent profile 3 or 4 may not deploy without a record of retention by a MMRB or a PEB unless the MMRB Convening Authority waives this requirement. In all cases, the role of the commander is to ensure Soldiers do not violate their profiles and are assigned duties that they can perform without undue risk to health and safety. Family member screening prior to overseas assignment will be completed according to AR 608–75, using DA Form 5888 (Family Member Deployment Screening Sheet).

e. It is the commander's responsibility to counsel Soldiers with physical profiles that may affect their deployment status. Medical guidance is critical in advising commanders of potential problems, physical limitations and potential situations that could be harmful to the Soldier or detrimental to the mission. Medical guidance is provided in the form of physical profiles documented on DA Form 3349 after being evaluated by an HCP. Soldiers will meet medical fitness standards in accordance with AR 40–501. Some Soldiers, because of certain medical conditions, may require administrative consideration when assigned to combat areas or certain geographic areas. As listed in AR 40–501, table 7–2, Profile codes, profiles address only physical functional capacity and limitations. Determination of a Soldier's assignment or duties, however, is the commander's responsibility and is outside of medical recommendations. As such, it is a commander's responsibility to counsel Soldiers on those duties they may or may not perform while deployed to combat areas or certain geographic areas. The counseled Soldiers will be advised that they will not violate their profiles and will perform duties assigned by the commander which they can perform without undue risk to health and safety.

f. See the DCS, G–1 personnel policy guidance message for additional deployment requirements on the DCS, G–1 Web site at http://www.armyg1.army.mil/militarypersonnel/ppg.asp. Medical standards for deployment are meant as general guides. The following medical conditions must be reviewed carefully by the medical provider before making a recommendation as to whether the Soldier can deploy to duty in a combat zone or austere isolated area where medical treatment may not be readily available.

(1) *Diabetes requiring insulin.* This requires an MEB/PEB (or for the RC, processing under paras 9–10 and 10–26). If found fit for duty, the Soldier should not deploy to areas where insulin cannot be properly stored (stored above freezing level but at less than 86 degrees Fahrenheit) or appropriate medical support cannot be reasonably assured. Deployment should only follow predeployment review and recommendation by an endocrinologist.

(2) *Diabetes requiring oral medication for control.* This requires a MEB/PEB (or for the RC processing under paras 9–10 and 10–26). If found fit for duty by a PEB, the Soldier may or may not be worldwide deployable (see table 5–1 for medical qualifications).

Table 5–1
Guidance on deployment of Soldiers with diabetes

Factor	OK to deploy	Should not be deployed
Hgb A1C (for patient)	At target	Not at target
Monofilament discrimination	Present	Absent
Autonomic neuropathy	Absent	Present
Knowledge of sick day rules	Sufficient	Insufficient
Proliferative diabetic retinopathy	Absent	Present
Macular edema	Absent	Present

Table 5–1
Guidance on deployment of Soldiers with diabetes—Continued

Severe hypoglycemia (an episode requiring another person's assistance)	Infrequent	Frequent
History of diabetic ketoacidosis in previous 6 months	No	Yes
Self-management skills	Good	Poor
Hypoglycemia unawareness	Absent	Present
Parameters of permanent profile can be followed	Yes	No
Significant co-morbidities (for example, congestive heart failure, chronic kidney disease, significant coronary artery disease, poorly controlled hypertension) requiring intensive management	Absent	Present
Risk of hypoglycemia is high if meals are missed or delayed	No	Yes
Duty will place the Soldier in an OCONUS-Isolated area where appropriate medical care and means to monitor and support him/her are not available	No	Yes

(3) *Cardiovascular conditions.* Review paragraphs 3–21 through 3–24 to determine if an MEB/PEB/trial of duty (or processing under paras 9–10 and 10–26) is necessary. If the Soldier successfully completes a trial of duty and is found fit for duty (or returned to duty by a Medical MOS Retention Board (MMRB)), the Soldier should not be deployed with any of the following conditions—

(a) Hypertension not controlled with medication.

(b) Recent episodes necessitating emergency room visits or closely monitored follow-up care.

(c) Permanent pacemakers, implanted antitachycardia and automatic implantable cardiac defibrillator (AICD) devices, and similar newly developed implanted cardiac devices require regular monitoring for battery life and functionality and should not be exposed to high electromagnetic fields. These particular devices have upper extremity physical limitations.

(d) Conditions requiring anticoagulants.

(e) Bare metal coronary stents. If the Soldier is found fit for duty by a PEB, the Soldier must remain at a location with access to a medical facility with the capability to do an urgent/emergent cardiac catheterization and laboratory monitoring of anti-platelet therapy for 3 months from the date of stent placement.

(f) Drug eluting coronary stents. If the Soldier is found fit for duty by a PEB, the Soldier must remain at a location with access to a medical facility with the capability to do an urgent/emergent cardiac catheterization and laboratory monitoring of anti-platelet therapy for 6 months from the date of stent placement.

(g) Closure device for patent foramen ovale or atrial septal defect. If the Soldier is found fit for duty by a PEB, the Soldier must remain at a location with access to a medical facility with echocardiography, cardiology and laboratory monitoring of anti-platelet therapy capabilities for 6 months from the date of the closure of the defect.

(h) Cardiac arrhythmias. If the Soldier has undergone an electrophysiology ablation procedure and the Soldier is found fit for duty by a PEB, the Soldier must remain at a location with access to cardiac monitoring capabilities for 6 months from the date of the ablation procedure.

(i) Smallpox vaccine associated myocarditis. If after an evaluation by a cardiovascular specialist, the Soldier is found to meet medical retention standards, the Soldier must remain at a location with access to echocardiography and medical monitoring for 6 months from the date myocarditis was diagnosed.

(4) *Neurological conditions.* Review paragraph 3–30 for profile guidance and MEB/PEB processing criteria.

(a) Seizure disorders. If the Soldier is controlled with medications and seizure free for one year, the Soldier may be assigned overseas but should not be assigned to areas where access to medications or where the ability to monitor anticonvulsant drug levels are not available.

(b) Demyelinating conditions. If a Soldier has been found fit for duty by a PEB (see paragraph 3–30*e)* for stable non-disqualifying demyelinating disease, the Soldier should not be subjected to austere environments or where there is no readily available access to environments of equal to or less than 80 degrees Fahrenheit.

(5) *Asthma.* See paragraph 3–27*a* for profile guidance and for MEB/PEB processing criteria. If it is determined that the Soldier can be returned to duty, the Soldier should not deploy if he/she cannot wear protective gear, has experienced recent emergency room visits, or requires repetitive use of oral corticosteroids.

(6) *Sleep apnea.* See paragraph 3–41*c* for profile guidance and for MEB processing criteria. The Soldier can be deployed if nasal continuous positive airway pressure (CPAP) is required and can be supported in the area of deployment.

Criteria for the ability to use nasal CPAP in the area of deployment include the following: availability of a reliable power source; absence of environmental factors that would render electrical equipment inoperable or unreliable, and the availability of a reliable source of replacement supplies such as masks, harnesses, and filters. A Soldier that requires nasal CPAP should not be deployed if these factors cannot be assured and the absence of nasal CPAP would hinder the Soldier from performing his/her military duties.

(7) *Musculoskeletal.* Soldiers with any recent musculoskeletal injury or surgery that prevents necessary mobility or firing a weapon should not deploy. Any chronic condition that restricts performance in the Soldier's MOS (for example, low back pain that prevents lifting) should be referred to an MEB/PEB (or processed under paras 9–10 and 10–26). If found fit for duty, the Soldier may be deployed unless he/she cannot function in the specific environment in which he/she is being assigned. Soldiers who meet medical retention standards but have a 3 in the profile cannot be deployed unless cleared by an MMRB.

(8) *Psychiatric.* (See ASD (HA) Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications for further information.)

(a) A psychiatric condition controlled by medication should not automatically lead to non-deployment. Soldiers with a psychiatric disorder in remission or whose residual symptoms do not impair duty performance may be considered for deployment duties. The commander makes the ultimate decision to deploy after consulting with the treating physician or other privileged provider. The availability, accessibility, and practicality of a course of treatment or continuation of treatment in theater or austere environment should be consistent with clinical practice standards. If there are any questions on the safety of psychiatric medication, a psychiatrist must be consulted.

(b) Psychotic and bipolar disorders are considered disqualifying for deployment.

(c) Psychiatric disorders that meet medical retention standards must demonstrate a pattern of stability without significant symptoms for at least 3 months prior to deployment.

(d) Soldiers must demonstrate behavioral stability and minimal potential for deterioration or recurrence of symptoms in a deployed, austere environment, to the extent this can be predicted. The potential for deterioration must be evaluated considering potential environmental demands and individual vulnerabilities.

(e) Medication disqualifying for deployment include—

1. Antipsychotics used to control psychotic, bipolar, and chronic insomnia symptoms; lithium and anticonvulsants to control bipolar symptoms;
2. Medications that require special storage considerations, for example, refrigeration;
3. Medications that require laboratory monitoring or special assessments, including lithium, anticonvulsants, and antipsychotics;
4. Medication prescribed within 3 months prior to deployment that has yet to demonstrate efficacy or be free of significant impairing side effects.

(f) Psychotropics clinically and operationally problematic during deployments include short half-life benzodiazepines and stimulants. Decisions to deploy personnel on such medications should be balanced with necessity for such medication in order to effectively function in a deployed setting, susceptibility to withdrawal symptoms, ability to secure and procure controlled medications, and potential for medication abuse.

(9) *History of exertional heat illnesses.* See paragraph 3–45 for profile guidance and MEB/PEB criteria. If there is any evidence of significant heat intolerance, the Soldier should not deploy to warm austere climates.

(10) *Pregnancy.* Pregnant Soldiers will not deploy.

(11) *History of cancer.* Soldiers with a history of cancer who have been returned to duty but have a requirement for periodic monitoring every 6 months or less should not deploy.

(12) *Chronic infectious diseases (HIV, Hepatitis B or C).* Soldiers will not deploy into the combat theater of operations. If found fit by a PEB, Soldiers may deploy to Europe or Korea (Host Nation permitting).

(13) *Abnormal cervical cytology.* Soldiers with recently treated moderate or severe dysplasia may only be deployed to austere environments if coordination is arranged via the unit commander and theater surgeon to ensure follow-up evaluation 7 to 9 months after initial evaluation and treatment.

(14) *Malignant hyperthermia.* Soldiers with history of malignant hyperthermia should not be assigned to areas where complete anesthesia services are unavailable or to austere environments.

(15) *Contact lenses.* Soldiers who must wear contact lenses to achieve vision standards and who cannot satisfactorily perform their MOS with their best spectacle correction or fall below vision retention standards with their best spectacle prescription should not deploy. Contact lens wear is not authorized in field environments or while deployed.

(16) *Miscellaneous conditions.* Soldiers pending and scheduled for required surgeries or still in rehabilitation post surgery with temporary profiles, pain syndromes requiring the use of medications (beyond simple NSAIDS), or the use of transcutaneous electrical nerve stimulator units, should not deploy.

(17) *Medications.* Soldiers taking medications should not automatically be disqualified for any duty assignment. Medications used for serious and/or complex medical conditions are not usually suitable for extended deployments. The medications on the list below are most likely to be used for serious and/or complex medical conditions that could likely result in adverse health consequences. This is not an all-inclusive listing of medications that may render an individual non-deployable but is provided as a guideline to be used during pre-deployment medical screening. Because some medications are used for multiple reasons, any medical screening should take into account whether the drug is being used for a serious and/or complex medical condition or another use that might be appropriate for a deploying Soldier. A complete medical evaluation should be initiated on those personnel regularly taking the following medications:

- Antiarrhythmics.
- Antiasthmatics (long acting beta-agonists and inhaled corticosteroids only).
- Anti-cancer/chemotherapy agents.
- Anticoagulants (for example, heparin, warfarin).
- Anticonvulsants (for the treatment of seizure disorder).
- Antidepressants (moderate to severe cases, bipolar, or unstable patients).
- Anti-gout medications (for example, allopurinol, colchicines).
- Anti-HIV medications.
- Antimania (lithium).
- Antiparkinsonians.
- Antipsychotics.
- Antithyroid medications (propylthiouracil (PTU), methimozole).
- Anti-tumor necrosis factor (for example, enteracept, and so on).
- Any injectable medications.
- Any type of insulin.
- Any type of medication (oral or injected) used for the purpose of treating diabetes.
- Chronic anxiolytics.
- Chronic immunosuppressants (for example, azathioprine, cyclosporin, and so on).
- Chronic narcotic analgesics.
- Coronary vasodilators (nitrates).
- Heart failure medications.
- Hematologics (for example, EPO, G–CSF, GM–CSF, and so on).
- Immunomodulators (for example, interferons, methotrexate, and so on).
- Inflammatory bowel disease medications (for example, mesalamine, sulfasalazine, and so on).
- Metformin (see para *5–14e(2)*).

(18) *Dental.* Soldiers that are in Dental Fitness Classification (DFC) 3 or 4 should not automatically be disqualified for any duty assignment. DFC 3 or 4 Soldiers should receive the necessary dental exam/treatment to make them at least a DFC 2 and thus deployable. Certain geographical areas with specific operational demands and limited access to care may require that the Soldier be in DFC 1 prior to deployment.

g. Medical Standards for Military Assistance Advisory Groups (MAAGs), military attaches, military missions, and duty in isolated areas where adequate medical care may not be available are listed below in paragraphs 5–14*f* (1)–(5). (See AR 55–46, AR 614–200, and AR 600–8–101.) These fitness standards also pertain to dependents of personnel being considered. The following medical conditions and defects will preclude assignments or attachment to duty with MAAGs, military attaches, military missions, or any type of duty in OCONUS isolated areas where adequate medical care is not available:

(1) A history of emotional or mental disorders, including character disorders, of such a degree as to have interfered significantly with adjustment or are likely to require treatment during this tour.

(2) Any medical conditions where maintenance medication is of such toxicity as to require frequent clinical and laboratory follow up or where the medical condition requires frequent follow up that cannot be delayed for the extent of the tour.

(3) Inherent, latent, or incipient medical or dental conditions that are likely to be aggravated by the climate or general living environment prevailing in the area where the Soldier is expected to reside, to such a degree as to preclude acceptable performance of duty.

(4) Of special consideration are Soldiers with a history of chronic cardiovascular, respiratory, or nervous system disorders who are scheduled for assignment and/or residence in an area 6,000 feet or more above sea level. While such individuals may be completely asymptomatic at the time of examination, hypoxia due to residence at high altitude may aggravate the condition and result in further progression of the disease. Examples of areas where altitude is an important consideration are La Paz, Bolivia; Quito, Ecuador; Bogota, Columbia; and Addis Ababa, Ethiopia.

(5) Remediable medical, dental, or physical conditions or defects that might reasonably be expected to require care during a normal tour of duty in the assigned area are to be corrected prior to departure from CONUS.

5–15. Height—U.S. Military Academy, Reserve Officers—Training Corps, and Uniformed Services University of Health Sciences

The following applies to all candidates to the USMA, the ROTC, and the USUHS. Candidates for admission to the USMA, the ROTC, and the USUHS who are over the maximum height or below the minimum height will automatically be recommended by DODMERB for consideration for an administrative waiver by HQDA during the processing of their cases.

Chapter 6
Aeromedical Administration

6–1. General

a. This chapter provides—

(1) Administrative policies for completing the Army flying duty medical examination (FDME) and the flying duty health screen (FDHS).

(2) General policies for the review and disposition of aeromedically disqualified aviation training program applicants, aircrew, and ATCs.

b. The FDME is a periodic physical examination performed for occupational and preventive medicine purposes to promote and preserve the fitness, deployability, and safety of aviation personnel and resources. The FDME is a screening examination used as a starting point for the careful evaluation and treatment of aircrew member health problems. The FDME focuses on the history, vision, hearing, and cardiopulmonary and neuropsychiatric systems. The FDME and supporting documents provide the aviation commander and Director, U.S. Army Aeromedial Activity (USAAMA) with information to make a final determination of medical fitness for flying and ATC duties.

c. The FDHS is an interim health screening evaluation, done annually, between comprehensive FDMEs to ensure maintenance of aircrew health and fitness for aviation duty and serves an opportunity for health promotion and annual PHA. (See ATB, Administrative Guide.)

6–2. Definition of terms

a. AR 600–105 and AR 600–106 provide additional definitions and policies pertaining to aviation duties.

b. The terms aircrew duties, ATC duties, aviation service, flying status, flight status, and flying duty are essentially interchangeable.

c. The terms aircrew and aircrew member are interchangeable. They are personnel who are in or graduated from aviation or ATC training programs. (See paras 4–1 and 4–2.)

d. Aeromedical standard of care is the minimum level by which a FS/APA/AMNP/AME conducts a comprehensive aviation medicine program to conserve aircrew health maintenance, flight safety, and operational readiness. The basis of the standard is promulgated by TSG through regulations, APLs, and ATBs.

e. Aviation training programs are military courses of instruction that prepare personnel to perform rated or nonrated flying duties or ATC duties.

f. A U.S. military FS is a physician awarded the aeronautical designation of FS after graduation from a basic course in U.S. military aviation medicine.

g. An aerospace medicine specialist is a FS who successfully completed a residency in aerospace medicine, or equivalent as determined by the American Board of Preventive Medicine or TSG.

h. An aeromedical physician assistant (APA) is a physician assistant who successfully completed the U.S. Army Flight Surgeon Primary Course. An aviation medicine nurse practitioner (AMNP) is a family nurse practitioner who successfully completed the U.S. Army Flight Surgeon Primary Course. An aeromedical examiner (AME) is a physician who has had sufficient aeromedical training to allow him/her to independently conduct FDMEs/FDHSs, write aeromedical summaries, and issue DD Form 2992. The aeromedical training must be validated and approved by the Dean, USASAM and the Director, USAAMA.

i. The ACAP is a panel of senior Fort Rucker rated aviators designated by the Commander, U.S. Army Aviation Center, and RAMs/FSs with multiple medical specialty credentials designated by the Director, USAAMA, to include representatives from the U.S. Army Combat Readiness Center, the U.S. Army School of Aviation Medicine, and the U.S. Army Aeromedical Research Laboratory.

j. An Aeromedical Summary is a medical evaluation containing medical history, physical, and supportive materials prepared by a FS/APA/AMNP/AME and forwarded to USAAMA for making a final determination of medical fitness for flying duties.

k. Aeromedical disqualification (DQ) is a medical condition that is unfitting for aviation or ATC duties as prescribed in chapters 2 and 4. AR 600–105 contains definitions and procedures for temporary medical suspension, medical termination of aviation service, aeromedical waivers, and return to aviation service after termination of aviation service. AR 600–105 defines procedures for nonmedical disqualifications for aviation service, FEBs, and in-flight aeromedical evaluations.

l. Temporary aeromedical DQ is a failure to meet a standard of medical fitness for flying duties due to a minor, self-limited condition that is likely to resolve and result in re-qualification within 365 days. A temporary aeromedical DQ will become a permanent aeromedical DQ if the DQ condition persists for more than 365 days.

m. Permanent aeromedical DQ is a failure to meet a standard of medical fitness for flying duties due to a condition that will either require a waiver for continuation of aviation service or result in medical termination of aviation service.

n. Full flying duties (FFD) is a recommendation of medical fitness permitting flying or ATC duties as annotated by a FS/APA/AMNP/AME on DD Form 2992.

o. The DNIF is a recommendation of medical unfitness prohibiting flying or ATC duties as annotated by a FS/APA/AMNP/AME or other health care professional on DD Form 2992.

p. Date of medical incapacitation is the date a disqualifying medical condition was definitively diagnosed by history, examination, or test. The effective date of medical termination from aviation service is based on this date. This date may not always correspond with the date of DNIF issued by the local FS/APA/AMNP/AME on DD Form 2992.

q. Temporary flying duty clearance pending receipt of waiver may be granted following the guidance in APLs for certain conditions.

r. Aeromedical Epidemiology Resource Office (AERO) is the electronic, online paperless physical exam system that should be utilized for all Army Flight Duty Medical Examinations (FDME), interim FDME (also known as the Flight Duty Health Screens (FDHS)) and aeromedical summaries (AMS).

6–3. Application

The provisions of this chapter apply to FDMEs and Aeromedical Summaries accomplished for aircrew performing aviation or ATC duties in DA aircraft, aircraft leased by the DA, or in Army ATC facilities. This includes Active Army and RC personnel, to include ARNG/ARNGUS, DACs, and contract civilians under employment by the DA or firms under contract to the DA as per Chapter 4.

6–4. Army Aviation Medicine Program responsibilities

a. TSG is responsible for the Army Aviation Medicine Program. (See AR 40–3.)

b. The AMC to TSG—

(1) Provides recommendations on the recruitment, selection, utilization and assignment of FSs, APAs, AMNPs, and aerospace medicine specialists.

(2) In coordination with the Director, USAAMA, develops aeromedical policy and standards for aircrew selection, retention, operational effectiveness, and safety.

(3) In coordination with USAAMA, recommends medical fitness policy and standards for Army aircrew members to TSG.

(4) Develops memoranda of understanding between the Chief, Aviation Branch; Commander, AHRC; Chief, NGB; Commander, USAMEDCOM; and TSG as required.

c. The Director, USAAMA, supervises the Activity, the Aeromedical Consultative Service (ACS), and the ACAP, and maintains the Aviation Epidemiology Data Register (AEDR).

d. The Director, USAAMA, coordinates with the AMC to TSG, and aviation waiver authorities and—

(1) Implements and monitors aeromedical policy and standards for aircrew selection, retention, operational effectiveness, and safety.

(2) Develops a consensus of opinion on the final aeromedical recommendation of flying duties fitness for aircrew training applicants and trained aircrew members through the aeromedical review process. (See paras 6–6 through 6–20.)

(3) Monitors the quality and implementation of the FDME/FDHS program.

(4) Manages the ACAP, the ACS, and the Aircrew Epidemiology Branch.

(5) Monitors and manages the AERO system.

e. The ACAP provides consultation and opinions on selected issues and aeromedical board cases pertaining to aeromedical policy, standards, and fitness for flying duties. (See para 6–2*i*.)

f. The Chief, ACS reviews FDMEs, FDHSs, aeromedical board summaries, and organizes tertiary aeromedical consultation and in-flight evaluations of disqualified aircrew members. Selected and eligible aircrew members may be referred to the tertiary aeromedical consultative services of the U.S. Air Force, U.S. Navy, and Allied Nations when approved by the authorities of those services. Requests for tertiary aeromedical consultation are forwarded through the local FS/APA/AMNP/AME to Director, U.S. Army Aeromedical Activity (MCXY–AER), Fort Rucker, AL 36362–5333, (334) 255–7340. (See AR 600–105.)

g. The Chief, Aircrew Epidemiology Branch, manages the AEDR. The AEDR is a DA-directed aeromedical database for Army aircrew. As directed by TSG, the AEDR is established and maintained by USAAMA.

h. The Dean, U.S. Army School of Aviation Medicine—

(1) Manages the aeromedical policy and standards education of FSs, APAs, AMNPs, AMEs, flight medical aidmen, aeromedical evacuation aviators, and other health care providers supporting the aviation medicine program.

(2) Provides verification of aeromedical policy and standards compliance in the local aviation medicine clinic through the Aviation Resource Management Survey inspection program.

(3) Manages aeromedical physiologic education and training of aircrew members.

i. Directors of health services, MTF commanders, command surgeons, and aviation unit commanders implement the Army Aviation Medicine Program at the local level by providing trained personnel, equipment, and facilities for the proper conduct of the program. They ensure expeditious, accurate completion of FDMEs and aeromedical summaries by military and civilian FSs, APAs, AMNPs, and AMEs.

j. Local FS/APA/AMNP/AME—

(1) Provide clinical and preventive medicine care to aircrew members and airfield support personnel. Provide area support for the aviation medicine care of Army RC, ARNG/ARNGUS, ROTC, and Army Recruiting units (See AR 40–3, chapter 3).

(2) Manage the aeromedical certification of aircrew and ATC by issuance of DD Form 2992, periodic aviation medicine examinations, in-flight evaluations, and aeromedical summaries.

(3) Assist commanders in providing aircrew physiologic and survival training as specified in FM 3–04.301.

(4) Serve as aviation unit staff officers and members of mishap investigation, aviation safety, and FEBs as per AR 600–105, AR 385–10, and DA Pam 385–90.

(5) Develop, implement, and exercise the medical portion of the airfield accident response plan and unit operations, mission, and deployment plans.

(6) Conduct flight line inspections of aviation life support equipment and crash protection systems.

(7) Participate in all aspects of the unit flight mission as per AR 600–105.

6–5. Authorizations

a. The AMC to TSG is the proponent office for chapters 4 and 6.

b. The AMC to TSG, in coordination with the USAAMA, issues APLs and ATBs to administer chapters 4 and 6.

6–6. Classification of flying duty medical exams

Paragraph 4–2 outlines the medical standards classification for flying duties. SF 88 and SF 93 have been replaced by DD Form 2808 (Report of Medical Examination) and DD Form 2807–1 (Report of Medical History).

6–7. Purpose of flying duty medical exams

a. *Purpose categories.* The FDME purpose is recorded with the FDME classification in Item 15c of DD Form 2808. The FDME/FDHS process accomplishes the requirements for the Annual PHA. There are four purpose categories for FDMEs:

(1) *Initial FDME.* Initial FDMEs are performed on all Class 1 aviator training program applicants; and all other Classes applying for or awaiting initial aviation or aviation medicine training, inter-service transfer, transition from active duty to RC, after being out of the military for more than 4 years, or hiring into the DAC, or DA contract civilian aircrew work force. The results of Initial FDMEs are recorded on DD Form 2807–1, DD Form 2808, and on aeromedical continuation sheets.

(2) *Fort Rucker Class 1 FDME.* Class 1 aviator training program students must have a valid, approved Initial Class 1 FDME before acceptance into aviator training programs and upon arrival for flight training at Fort Rucker. Lyster Army Health Clinic (LAHC) will perform a Fort Rucker Class 1 FDME before the student is enrolled in flight training to revalidate that the student meets Class 1 medical standards of fitness for flying duties. A repeat Initial FDME will be performed

if the Initial FDME is no longer valid. The results of the Fort Rucker FDME are recorded on DD Form 2808, DD Form 2807–1, and associated aeromedical continuation forms; and if baseline medical history verification sheet from USAAMA is not available, USAAMA will determine a final recommendation.

(3) *Comprehensive FDME.* Comprehensive FDME. Comprehensive FDMEs are performed on all Classes of aircrew when Initial FDME or Interim FDHS are not required. (See para 6–8*b*, below.) The results of the Comprehensive FDME are recorded on DD Form 2808 and DD Form 2807–1. Report interim changes in medical history on DD Form 2807–1 if these changes were not previously documented on an AEDR Medical History Verification Report or Aeromedical Summary.

(4) *Interim FDME.* Interim FDHSs are performed on all Classes of aircrew when an Initial FDME or Comprehensive FDME is not required. (See para 6–8*b*, below.) The results of the Interim FDHS are recorded on DA Form 4497 (Interim (Abbreviated) Flying Duty Medical Examination) or DD Form 2808 with identified blocks specific for interim FDHS completion. Report interim changes in medical history on DD Form 2807–1 if these changes were not previously documented on an AEDR Medical History Verification Report or Aeromedical Summary.

b. *Guidelines.* Refer to ATB 2, Army Flight Surgeon's Administrative Guide, for guidelines on completing each category of examination.

6–8. Frequency and period of validity of FDMEs

a. Class 1 validity is as follows:

(1) *Initial Class 1 FDME.* The Initial FDME is valid for a period of 18 months from the date of examination. Repeat Initial FDMEs are required if the FDME validity expires while awaiting aviator training program selection or training class dates. The FDME must be valid and qualified by the Director, USAAMA, before the applicant's acceptance into aviator training programs and upon arrival for flight training.

(2) *Fort Rucker Class 1 FDME.* This physical is valid for up to 24 months to allow completion of the Flight Training programs. Upon graduation and PCS to the next duty station, the aviator will require completion of a FDME/FDHS and birth month realignment, as prescribed in ATB 2 and table 6–1.

b. Classes 2/2F/3/4 validity is as follows:

(1) *Initial FDME.* The Initial FDME is valid for a period of 18 months from the date of examination. Following the Initial FDME, subsequent Comprehensive FDMEs or Interim FDHSs will be aligned with the aircrew member's birth month using table 6–1.

(2) *Comprehensive FDME.* The Comprehensive FDME is performed every 5 years beginning with age 20, or as applicable, at ages 25, 30, 35, 40, and 45. Beginning with age 50, a comprehensive FDME is required annually. It will be performed within 90 days before the end of the birth month in the year it is due. The FDME is valid until the end of the next birth month. Comprehensive FDME shall be completed and submitted after any Class A and B mishap.

(3) *Interim FDME.* The Interim FDHS is performed in the interim years when an Initial or Comprehensive FDME is not required. It will be performed within 90 days before the end of the birth month and is valid until the end of the next birth month. If retiring, the period of validity will extend to 18 months past the birth month.

(4) *Rated aviators in aviation service.* Rated aviators in aviation service are required to maintain a Comprehensive or Interim Class 2 FDME even when not assigned to operational flying duty positions. (See AR 600–105.)

(5) *Additional comprehensive FDMEs.* These may be required following disqualifying illness or injury present for more than 12 months, post mishap investigation, or FEB. A comprehensive FDME is required for those who are terminated from aviation service and are requesting a return to aviation service.

(6) *Retirement.* If an FDME is required within 90 days of retirement from Federal service, a comprehensive FDME with the additional examination requirements for retirement (see chap 8) is required for active duty members, and is encouraged but not required for RC or civilian members.

c. The requirement to perform FDMEs will not be suspended in the event of training exercises or military mobilization unless authorized by TSG. Request authorization through the Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333, who will coordinate authorization with the AMC to TSG.

d. The FDME will be completed to the extent the MTFs permit when aircrew are on duty or in mobilization at a station OCONUS with limited military medical facilities. Email or attach a cover letter to the FDME addressed to Director, USAAMA (MCXY–AER), explaining the facility limitations. Accomplish the missing portions of the annual FDME/FDHS within 90 days upon return to a station with adequate medical facilities. Align subsequent Comprehensive or Interim FDHSs with the aircrew member's birth month using table 6–1.

e. During certain missions not supported by U.S. or allied military medical officers (for example, special operations), the FDME may be deferred by the Commander having custody of the field personnel files until the accomplishment of the FDME becomes feasible. Annotate the remarks section of DD Form 2992 with an explanation of the deferment.

6–9. Facilities and examiners

a. U.S. military or civilian FS/APA/AMNP/AMEs at MTFs will conduct initial FDMEs. Initial FDMEs will meet the Army-specific administrative requirements for the completion of such FDMEs as outlined in ATB 2, Army Flight Surgeon's Administrative Guide. The FS/APA/AMNP/AME will apply U.S. Army aeromedical standards from chapters 2 and 4 for the determination of medical fitness for flying duty.

b. Comprehensive FDMEs and Interim FDHSs for all Classes will be conducted when possible by trained FS/APA/AMNP/AMEs. The FDME may be conducted by any military, DAC, contract civilian physician, or non-aeromedically trained PA or FNP when a FS/APA/AMNP/AME is not available, but only a FS shall review and sign the DD Form 2808 and DD Form 2807–1 or DA Form 4497 prior to sending by mail or AERO the FDME to USAAMA for central review. When a FDME is performed at non-U.S. Army medical facilities, the FDME will be conducted by a military FS/APA/AMNP/AME to meet the administrative requirements of that branch of the U.S. Armed Forces or host Allied nation in accordance with STANAG 3526 and AR 12–15. APL, Aeromedical Cardiovascular Screening Program, still applies. The FS/APA/AMNP/AME must apply Army aeromedical standards from chapters 2 and 4 for the determination of medical fitness for flying duties. FDMEs performed by host Allied nations may be completed in English on Allied documents designed for the same purpose when DD Form 2808 and DD Form 2807–1 are not available. Outline unusual circumstances in a memorandum for record included with the FDME.

c. The DAC or DA contract civilian providers with a previous military aeronautical rating of FS/APA/AMNP/AME practicing in medical specialties other than aviation medicine may be credentialed to complete FDMEs. The U.S. Army School of Aviation Medicine provides Army Aviation Medicine refresher training for FSs/APAs/AMNPs/AMEs to meet credentialing requirements. Other physicians and health care professionals will sign the DD Form 2808 for the portions of the examination they accomplish. The FDME is invalid and incomplete without the signature of a military FS/APA/AMNP/AME on the DD Form 2808 and DD Form 2807–1 or DA Form 4497, and a final review stamp placed by the staff of USAAMA on the DD Form 2808 or DA Form 4497.

d. The APAs and AMNPs may conduct FDMEs/FDHSs and sign/submit normal FDMEs/FDHSs meeting aeromedical class standards and those with waivers meeting annual waiver requirements directly to USAAMA for review and disposition. All others (that is, new disqualifications or not meeting annual waiver requirements) must be reviewed and co-signed by the supervising flight surgeon for submission. In circumstances when supervising flight surgeon is unavailable, APAs/AMNPs shall annotate such on DD Form 2808, Block 73, "Notes" for USAAMA flight surgeon staff to assume that role. LAHC APAs and AMNPs may submit all FDMEs, FDHSs, and AMSs directly to USAAMA.

e. Consultations may be obtained at Government expense when authorized as stated below. (See also paras 4–3 and 4–32.)

(1) Additional tests, procedures, and consultations required to complete Initial FDMEs for all aircrew Classes, to include civilians, active duty, and RC, will be completed at military outpatient or inpatient MTFs. When fitness for flying duty cannot be determined, MTF commanders or ARNG/ARNGUS State Adjutant General's Office may permit supplementary examinations from civilian medical sources. The tests and consultations are conducted only to the extent required to determine medical fitness for flying duties and not for the treatment or correction of disqualifying conditions.

(2) Paragraph (1), above, applies to Comprehensive FDMEs and annual Interim FDHSs, except that treatment or correction of disqualifying conditions discovered during the FDME/FDHS will be completed if the examinee is eligible for such care (AR 40–400).

(3) The DACs or contract civilians utilizing Army flight standards and employed by DA or firms under contract by DA who are military retirees, RC, or ARNG/ARNGUS aircrew, may be authorized for such care. (See (1) and (2) above, and AR 40–400.)

(4) The DAC or contract civilian utilizing Army flight standards and may request a waiver of the disqualifying condition from the Director, USAAMA. The Director, USAAMA, will process any waiver request consistent with guidance for granting waivers.

(5) Director, USAAMA, may direct evaluation of disqualified aircrew eligible for care (AR 40–400) at any U.S. MTF or aeromedical consultation service.

f. The AERO (online system) is the primary method for entering and submitting FDME and AMS data.

6–10. Disposition and review of flying duty medical examinations

a. *Review.* The review of the individual health record and FDME/FDHS will be completed by the aeromedical health care provider. The aeromedical health care provider will counsel the examinee regarding—

(1) Conditions found during the FDME.

(2) Continuing care for conditions under treatment and/or waiver.

(3) General preventive health education, including, but not limited to smoking, cholesterol control, weight control, drug and alcohol abuse, and other high risk behavior.

b. *Profile status.* The examinee's current PULHES profile status shall be recorded in the PULHES section of the DD Form 2808. See APL, Unspecified Permanent Profiles (Ortho Chapter).

c. *Class 1 and initial Classes 2/2F/4.* Completed FDMEs (originals of DD Form 2807–1, DD Form 2808, aeromedical continuation sheet, interpreted EKG, and other supportive documents) accomplished for application to aviation and aviation medicine training programs will be forwarded through the procurement chain of command of the applicant via AERO preferred, or by mail as an alternate, to Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333 for central aeromedical review and disposition. The FS's office shall place copy of the FDME and all enclosures in the medical record and retain a copy in the office for a minimum of 2 years if submission is not accomplished via AERO. The AERO serves as a repository for the information. In no case will the originals be given to the applicant or other individuals not in the procurement chain of command. The Director, USAAMA, must make a final determination of fitness for flying duties before Classes 1/2F/4 applicants may be accepted and assigned to Fort Rucker for aviation, ATC, and aviation medicine training programs.

d. *Trained Classes 2/2F/4.* Completed Comprehensive and Interim FDHSs (DD Form 2808 and DD Form 2807–1 or DA 4497–R, aeromedical continuation forms, interpreted EKG, and other supportive documents, may include consultations, EKG tracings, radiographs, coronary angiogram, and so forth, and, if applicable, Aeromedical Summary) will be forwarded directly to Director, USAAMA, ATTN: MCXY–AER, Fort Rucker, AL 36362–5333, for central aeromedical review and disposition. The FS's office shall place copy of the FDME/FDHS and all enclosures in the medical record and retain a copy in the office for a minimum of 2 years if submission is not accomplished via AERO. AERO serves as a repository for the information.

e. *Class 3.* The attending FS/APA/AMNP/AME who signs the FDME/FDHS is the reviewing authority for recommending disposition on medical fitness for flying duty. Minor medical disqualifications that will in no way affect the safe and efficient performance of flying duties and that will not be aggravated by aviation duties or deployment may be waived by the individual's unit commander upon favorable recommendation by the attending FS/APA/AMNP/AME. (See also APL, Class 3 Aircrew, and para 4–33.) (See also ATB 2, Army Flight Surgeon's Administrative Guide, for details on the item-by-item completion of FDMEs.) AERO should be utilized for completion of Class 3 FDME/FDHS and AMS for the purpose of annotating and archiving aeromedical information in the AEDR repository.

f. *Tracking.* The flight surgeon or aviation unit will track FDMEs/FDHSs via AERO from initiation until posted in the health record with a final disposition by USAAMA. If disqualified, the flight surgeon and aviation unit will take action as per AR 600–105 and AR 600–106.

g. *Disposal of documentation.* Waiver and suspension recommendation and approval letters will be filed in the individual health record and flight record. When available, the AERO Abbreviated Waiver Letter shall be utilized for the individual flight record folder (IFRF) for Health Insurance Portability and Accountability Act (HIPAA) compliance of protected health information.

6–11. Issuing DD Form 2992

a. DD Form 2992 is an official document used to notify the aviation commander of certification of medical fitness for all classes of military and civilian aircrew utilizing Army standards for medical clearance.

b. The DD Form 2992 will be completed—

(1) After the completion of an FDME/FDHS.

(2) After an aircraft mishap.

(3) After an FEB.

(4) When reporting to a new duty station or upon being assigned to operational flying duty.

(5) When admitted to and discharged from any medical or dental treatment facility (inpatient or outpatient, military or civilian), sick in quarters, interviewed for or entered into a drug/alcohol treatment program, or when treated by a health care professional who is not a military FS/APA/AMNP/AME or otherwise authorized to issue a DD Form 2992.

(6) When treated as an outpatient for conditions or with drugs that do not meet the standard for aviation duties; and upon return to flight duties after such treatment and recovery.

(7) Upon return to flight status after termination of temporary medical suspension, issuance of waiver for aviation service, or requalification after medical or nonmedical termination of aviation service.

(8) Other occasions as required by the FS/APA/AMNP/AME.

c. Rated aviators not performing operational flying duties are required to complete an annual FDME/FDHS with issuance of DD Form 2992 (AR 600–105).

d. Each item of the DD Form 2992 will be completed as directed by the Director, USAAMA. (See ATB, DD Form 2992.) Three copies of the DD Form 2992 will be completed. Copy 1 is placed in the outpatient medical record. Copy 2 is forwarded to the examinee's unit commander who signs and forwards it to the flight operations officer for inclusion in the flight records (AR 95–1 and FM 3–04.300). Copy 3 is given to the examinee.

e. If the examinee is found qualified for flying duty by the local FS/ APA/AMNP/AME, see chapters 2 and 4. Issuance of the DD Form 2992 will constitute an aeromedical clearance for flying duty pending final review of the FDME/FDHS by the reviewing authority. The aeromedical clearance will expire when the current FDME/FDHS is no longer valid. (See para 6–8.)

f. If a disqualifying medical condition is found, a waiver must be granted by the appropriate authority before further flying duties are performed. (See paras 6–12 through 6–20.) For minor defects that will not preclude safe and efficient performance of flying duties and will not be aggravated by aviation duty or military mission, the local commander may permit an individual to continue performance of aviation duties pending completion of the formal waiver process and upon favorable recommendation for temporary FFD by the local FS/APA/AMNP/AME following the guidelines in APL, Temporary Flying Duties.

g. When used to recommend temporary flying duties, the Remarks section of DD Form 2992 will be completed to reflect a limited length of time for which the clearance is issued, for example: "Temporary FFD, 90 days, pending receipt of waiver."

h. The FS/APA/AMNP/AME will consult the Director, USAAMA (MCXY–AER), or the major Army command's Aviation Medicine consultants in U.S. Army, Europe or Korea, before issue of DD Form 2992 for complex or questionable cases.

i. The validity period of the current FDME/FDHS (see para 6–8) may be extended for a period of 1 calendar month beyond the birth month on the DD Form 2992. After expiration of this extension, the aircrew member or ATC must complete the FDME/FDHS and be medically qualified or be—

(1) Administratively restricted from flying duties if no aeromedical DQ exists and be considered for a non–medical DQ and FEB (AR 600–105).

(2) Medically restricted from flying duties if an aeromedical DQ exists. In some cases, temporary flying duties may be recommended on DD Form 2992. (See also *f*, above, and paras 6–12 through 6–20.)

j. Personnel authorized to sign the DD Form 2992 are as follows:

(1) Any physician or health care provider may sign DD Form 2992 for the purpose of restricting aircrew and ATCs from aviation duties when an aeromedical DQ exists. (See *b*, above, and chap 4.)

(2) A FS/APA/AMNP/AME may sign the DD Form 2992 to return aircrew and ATCs to FFD. Recommended restrictions will be annotated in the Remarks block of DD Form 2992. (The previous requirement for an APA (and AMNP) to have the FS review the medical record and cosign within 72 hours is no longer required.)

(3) A non-aeromedically trained provider under the supervision of a FS may sign the DD Form 2992 to recommend returning aircrew and ATCs to FFD when a FS is not locally available by obtaining case-by-case telephonic guidance from a FS. The name of the consulted FS will be annotated on DD Form 2992, and on an SF 600 (Medical Record—Chronological Record of Medical Care) in the patient health record.

k. Forms of the other branches of the U.S. Armed Forces and host Allied nations similar to DD Form 2992 will be accepted by the Army when aeromedical support is provided by those Service/nations and DD Form 2992 is not available.

l. Contract aircrew utilizing FAA for aeromedical certification shall possess the applicable FAA Form 8500–9, Medical Certification, in lieu of DD Form 2992.

6–12. General principles

a. The Director, USAAMA, is authorized to issue APLs and ATBs that are regulatory in nature. These detail aeromedical policy and disposition for common aeromedical DQs and establish an Armywide standard of aeromedical care. These series may be obtained from Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333 or via the website at: https://aamaweb.usaama.rucker.amedd.army.mil/.

b. The FS/APA/AMNP/AME will make the initial determination of medical unfitness due to failure to meet a medical standard for—

(1) Aircrews. (See chaps 2 and 4, and AR 600–105.) The final determination of medical fitness for flying duties is made by the Director, USAAMA. Although MEB and PEB documents (AR 40–400 and AR 635–40) are valuable sources of information, the final recommendation of medical fitness for flying duty is made independent of the recommendations of these boards. The Director, USAAMA may review the proceedings of FEBs (AR 600–105) in determining fitness for flying duties.

(2) Personnel retention, retirement, or separation. (See chap 3.) The final determination of medical fitness for personnel retention, retirement, or separation is made by the MEB and PEB process (AR 635–40). In the case of aircrew members, the president of the PEB may request a consultation from the Director, USAAMA, or delay final determinations until the medical fitness for flying duties is determined by the Director, USAAMA.

c. The FS/APA/AMNP/AME will complete a history, physical, tests, and consultations to the extent required to—

(1) Confirm the medical disqualification.

(2) Recommend an aeromedical disposition.
(3) Meet the aeromedical standard of care in accordance with APLs and ATBs.

d. For all flying classes, each disqualifying defect or condition will be evaluated to determine if it—
(1) Is progressive.
(2) Is subject to aggravation by military Service.
(3) Precludes satisfactory completion of training and/or military service.
(4) Constitutes an undue hazard to the individual or to others.

e. The FS/APA/AMNP/AME will consider the factors involved in the use of medicines (APL, Medications) for treatment of the condition and determine if—
(1) The medication is effective without aeromedically significant side effects.
(2) There is a problem with medication compliance.
(3) The medication is readily available during mobilization.
(4) The medication does not mask symptoms subject to acute incapacitation or complications in the aviation environment.

f. The FS/APA/AMNP/AME will consider whether continued flying duty may—
(1) Compromise personal health.
(2) Pose a risk to aviation safety.
(3) Jeopardize mission completion.
(4) Result in deployability limitations.

g. The FS/APA/AMNP/AME will determine the date of medical incapacitation. The date of medical incapacitation is the date the aeromedical DQ is diagnosed by history, physical examination, or testing. The date of aeromedical incapacitation may not always correspond with the dates of local medical restriction from flying duties by an FS/APA/AMNP/AME using DD Form 2992 or the date an FS/APA/AMNP/AME first evaluates the aeromedical DQ.

h. For the purpose of aeromedical DQs, the immediate aviation commander is defined as the aviation unit commander or designated official who maintains the aircrew member's flight or ATC records.

i. Each aeromedical DQ requires—
(1) Temporary medical suspension until the aircrew member is requalified and meets the medical standards of fitness for flying duties within 365 days (para 6–17); or
(2) Medical termination from aviation service (permanent medical suspension) due to a temporary medical suspension imposed for greater than 365 days or a permanent aeromedical DQ without waiver (para 6–18); or
(3) Aeromedical waiver granted by the aviation service waiver authority permitting aviation service despite an aeromedical DQ (para 6–19). (See ATB 3, Aeromedical Summary, for policy on the preparation of the Aeromedical Summary document, and ATB 4, Aeromedical Consultation Service, for policy on use of this service. See also ATB 2, Army Flight Surgeon's Administrative Guide.)

6–13. Responsibilities and review following a change in health of aircrew members

a. Aircrew members will report to a FS/APA/AMNP/AME the following conditions:
(1) Symptoms indicating a change in health.
(2) An illness requiring the use of medications, a visit to a health care provider for evaluation and/or medical-dental care, restriction to quarters, or hospitalization.
(3) Drug or alcohol use that results in legal problems (driving under the influence, driving while intoxicated, positive blood or urine drug screen, arrests for intoxication, family member abuse, and so forth), psychological dysfunction (absence or tardiness from work or school, severe marital discord, and so forth), medical or psychological incapacitation, or history of evaluation and/or treatment for drug/alcohol misuse, abuse, or dependence.
(4) Current aeromedical waivers or requests for waiver.
(5) Positive HIV.

b. Aircrew members must inform their FS/APA/AMNP/AME when they have participated in activities, or received treatment for which flying restrictions may be appropriate in accordance with AR 40–8. Treatment means any medical treatment or procedure performed by a non-aeromedical health care provider, and includes, but is not limited to, the following:
(1) Any medical or dental procedure requiring use of medications after treatment.
(2) Any medical or dental procedure requiring use of any type of anesthesia or sedation.
(3) Referral for psychological, social, or psychiatric counseling, to include any kind of alcohol or substance abuse counseling.
(4) Any chiropractic or osteopathic manipulative treatment.

(5) Any treatment given by a homeopath, naturopath, herbalist, acupuncturist, or other "alternative medicine" practitioner.

(6) Emergency room visits, or treatment given by a civilian health care provider.

c. The immediate aviation commander will request an aeromedical consultation with a local FS/APA/AMNP/AME when an aircrew member develops a change in health. (See a above.)

d. The local FS/APA/AMNP/AME will make a preliminary determination of medical fitness for flying duties and recommend FFD or DNIF by issuance of DD Form 2992. (See also paras 6–11 through 6–20.) Also, the attending FS/APA/AMNP/AME will forward the FDME/FDHS via AERO with pertinent attachments or Aeromedical Summary to Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333 for review and final recommendation. See ATB 2, Army Flight Surgeon's Administrative Guide, and ATB 3, Aeromedical Summary. For rated flying personnel who have been found per¬manently disqualified for aviation service and for whom waivers are not being considered, Director, USAAMA (MCXY–AER) will notify the FAA. Authority is according to 5 USC 552a(b)7.

e. In the case of a permanent aeromedical disqualification (DQ), the Director, USAAMA (MCXY–AER), makes the final recommendation of medical fitness for flying duties to the aviation service waiver authority.

f. The aviation service waiver authority reviews the recommendation of medical fitness for flying duties and makes the final administrative disposition for—

(1) Medical termination from aviation service (permanent medical suspension); or

(2) Continuation of aviation service with administrative aeromedical waiver.

g. The aviation service waiver authorities are listed in paragraph 6–20.

h. The aeromedical consultation authority is Director, USAAMA, ATTN: MCXY–AER (Chief, Aeromedical Consultation Service), Fort Rucker, AL 36362–5333.

6–14. Review and disposition of disqualifications for Class 3

a. The FS/APA/AMNP/AME who signs the FDME is the reviewing authority and will make decisions on aeromedical disposition. Minor physical defects that will not affect the safe, efficient performance of flying duties or mission and will not be aggravated by aviation duties or deployment may be waived by the individual's unit commander, the Class 3 waiver authority, upon favorable recommendation by the FS/APA/AMNP/AME. (Exceptions are stated in paras 4–32 and *d* below.)

b. Notification of aeromedical DQ will be forwarded on DD Form 2992 to the aviation unit commander, along with appropriate recommendations for waiver of DQs or suspension from flying duties in accordance with existing directives.

c. An Aeromedical Summary (AERO preferred) discussing the case and the basis for aeromedical decision will be prepared by the FS/APA/AMNP/AME and placed in the aircrew member's individual health record for future reference by the aviation commander and other FS/APA/AMNP/AMEs.

d. Cases involving drug/alcohol abuse or dependence, or complicated questionable cases shall be forwarded to Director, USAAMA (MCXY–AER), for review and disposition. (See also APL, Class 3, Aircrew.)

6–15. Review and disposition of disqualifications for Classes 2/2F/4

a. Initial and periodic FDMEs will be submitted to Director, USAAMA, for review and disposition. (See para 6–10*d*.)

b. If the aircrew member is found medically qualified, the FS/APA/AMNP/AME prepares a DD Form 2992 and recommends clearance for FFD. (See para 6–11.)

c. If a disqualifying defect is discovered, the FS/APA/AMNP/AME completes the evaluation and recommends temporary medical suspension, termination from aviation service (permanent suspension), or waiver of the disqualifying defect. (See paras 6–17 through 6–20.)

6–16. Temporary medical suspension

a. A temporary medical suspension restricting aircrew from flying duties is required for temporary aeromedical DQs that are minor, self–limited, and likely to result in requalification within 365 days. Examples include ankle sprain, acute rhinitis, gastroenteritis, and simple closed fracture.

b. Medical termination from aviation service (see para 6–18) is mandatory if the temporary medical suspension exists for greater than 365 days (AR 600–105 and DOD 7000.14–R, Vol 7A). In this case, the temporary medical DQ becomes a permanent medical DQ.

c. The local FS/APA/AMNP/AME will evaluate all aircrew with possible aeromedical DQs as identified by the aviator, immediate commander, FS/APA/AMNP/AME, or USAAMA. The FS/APA/AMNP/AME will follow the established standards of aeromedical care (this regulation and APL and ATB series).

d. The FS/APA/AMNP/AME will recommend a date of medical incapacitation and recommend DNIF on DD Form 2992.

e. The immediate commander will set the date of medical incapacitation and impose the temporary medical suspension.

f. Aircrew under temporary medical suspension may not be assigned flying/ATC duties or operate the flight controls of a military aircraft. As an exception, the FS/APA/AMNP/AME may recommend by DD Form 2992 that the officer operate flight simulators, perform ground run-up procedures, and/or undergo an aeromedical consultation with in-flight evaluation. (See AR 600–105.)

g. The immediate commander may remove the temporary medical suspension upon favorable recommendation by a FS/APA/AMNP/AME on DD Form 2992.

h. The FS/APA/AMNP/AME will recommend medical termination from aviation service (permanent medical suspension) if the term of temporary medical suspension has or is expected to exceed 365 days. The FS/APA/AMNP/AME will notify the immediate commander by DD Form 2992 and forward an Aeromedical Summary to Director, USAAMA, ATTN: MCXY–AER.

6–17. Medical termination from aviation service

a. Medical termination from aviation service (permanent medical suspension) is required for permanent aeromedical DQs that are not likely to result in requalification within 365 days. Continuation of flying duties is only authorized by issuance of orders for an aeromedical waiver (para 6–19) by an aviation service waiver authority.

b. The local FS/APA/AMNP/AME will evaluate the aeromedical DQ and make a preliminary determination of medical fitness for flying duty.

c. The FS/APA/AMNP/AME will recommend a medical termination from aviation service (permanent medical suspension) on DD Form 2992 and forward the notification to the immediate commander.

d. The FS/APA/AMNP/AME will prepare an Aeromedical Summary and forward to Director, USAAMA, ATTN: MCXY–AER.

e. The Director, USAAMA, ATTN: MCXY–AER will make final recommendations to the aviation service waiver authority and recommend a—

(1) Date of medical incapacitation.

(2) Final aeromedical disposition:

(a) Medical termination from aviation service; or

(b) Aeromedical waiver for continuation of aviation service with the permanent aeromedical DQ; or

(c) Requalification without aeromedical DQ ("For Information Only").

f. The aviation service waiver authority will—

(1) Establish the date of medical incapacitation.

(2) Establish the date of medical termination from aviation service and publish an order (AR 600–8–105).

(3) Refer the aircrew member to the appropriate authority for reclassification, rebranching, or Service separation.

(4) Send the health record back to the MTF of origin.

g. The FAA Federal Air Surgeon requires the Director, USAAMA to report all termination from aviation service actions. This may be done without the knowledge or consent of the aircrew member (5 USC 552).

6–18. Aeromedical waiver

a. In the case of permanent aeromedical DQ, the aircrew member may request consideration for an aeromedical waiver for aviation service through a local FS/APA/AMNP/AME.

b. The FS/APA/AMNP/AME will complete an evaluation within the aeromedical standards of care (this regulation and APL and ATB series). The FS/APA/AMNP/AME will prepare an Aeromedical Summary and forward to Director, USAAMA (MCXY–AER).

c. The Chief, ACS will—

(1) Review the case.

(2) Arrange for additional evaluation by aeromedical consultants designated by Director, USAAMA as required.

(3) Authorize and arrange for additional evaluations at U.S. Air Force or U.S. Navy aeromedical consultation services as required.

(4) Arrange for in–flight evaluations as required (AR 600–105).

(5) Present selected cases to the ACAP.

(6) Refer the case with recommendations to Director, USAAMA, ATTN: MCXY–AER.

d. The Director, USAAMA will—

(1) Formulate a consensus of aeromedical opinion on the medical fitness for flying duty.

(2) Determine if an aeromedical waiver can be recommended, and if so, determine if the waiver will require recommendations for specific restrictions in the flight environment and/or specific followup medical evaluations to maintain the waiver.

e. The Director, USAAMA will forward final recommendations to the aviation waiver authority.

f. The aviation service waiver authority will—

(1) Review the aeromedical recommendations and supportive enclosures, consider the needs of the U.S. Army, and make a final determination to grant or deny an aeromedical waiver.

(2) Publish orders to permit continuation of aviation service with a waiver or medical termination from aviation service (permanent medical suspension).

(3) Send the health record back to the MTF of origin.

g. The aircrew member will acknowledge the waiver, and if applicable, restrictions and followup evaluation, in writing to the aviation service waiver authority. Failure to do so, or declining the waiver, will be considered a nonmedical DQ due to dereliction of duty and may result in an FEB (AR 600–105).

h. The FS/APA/AMNP/AME may recommend amendments to the conditions for continuation of waivers in effect, as required, by submitting written justification along with supportive documents to the Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333.

i. If the condition resolves or is no longer disqualifying due to policy and standard changes, the FS/APA/AMNP/AME may recommend revocation of an aeromedical DQ to the Director, USAAMA.

6–19. Aeromedical requalification

a. An aircrew member with a medical termination from aviation service may request aeromedical requalification if the medical DQ resolves.

b. The procedure for requesting requalification is the same as the procedure for aeromedical waiver (para 6–19), except the aviation service waiver authority will determine if requalification meets the needs of the Army, and if so, will—

(1) Publish orders establishing date of the aeromedical requalification.

(2) Publish orders of assignment and travel.

(3) Issue an administrative waiver if required.

6–20. Waiver and suspension authorities

a. Personnel who are dual-status (such as ARNG/ARNGUS members and DACs) will require a waiver or suspension action from each authority they are assigned.

b. Active Army, USAR, or International Military Pilots and Flight Students of non-NATO or Partnership for Peace (PfP) countries—Class 1 and Class 2: through Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333; for Commander, AHRC (TAPC–PLA), 200 Stovall Street, Hoffman Building, Room 3N25, Alexandria, VA 22332–0413.

c. Active Army or USAR—Class 2F/2P; and Class 3 aeromedical positions of aviation audiologists, dentists, optometrists, and psychologists requiring a central waiver (see APL, Class 3 aircrew): through Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333; for Commander, AHRC, Health Services Division (TAPC–OPH–MC), 200 Stovall Street, Hoffman Building, Room 9N68, Alexandria, VA 22332–0413.

d. Active Army or USAR—Class 3 (requiring a central waiver (see APL, Class 3 aircrew)), and Class 4: through Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333; for Commander, AHRC (TAPC–EPL–T), 2461 Eisenhower Avenue, Alexandria, VA 22331–0453.

e. ARNG/ARNGUS—Class 1, Classes 2/2F/4, and Class 3 (requiring a central waiver (see APL, Class 3 aircrew)): through Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333; for Chief, National Guard Bureau (NGB–AVN–OP), 111 South George Mason Drive, Arlington, VA 22204–1382.

f. Contract civilians — all Classes utilizing Army Flight Standards and not FAA for certification: through Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333; through the contracting officer representative, for the commanding general, or the commanding general who is designated the waiver authority of the installation with the DA contract (usually the airfield commander or the command aviation officer of the installation with the DA contract; for example, at Fort Rucker, Command Aviation Officer (DPT–AD), Fort Rucker, AL 36362). Final determination will then be forwarded to the Contracting Office and the firm under contract to DA.

g. DAC—all Classes: through Director, USAAMA (MCXY–AER), Fort Rucker, AL 36362–5333; through aviation unit Commander; for the Commanding General or the Commanding General who is designated the waiver authority (usually the airfield commander or command aviation officer; for example, at Fort Rucker, Command Aviation Officer (DPT–AD), Fort Rucker, AL 36362). Final determination will then be forwarded to the local Civilian Personnel Office.

h. Class 3, for other than centrally required waivers and as specified in the APLs/ATBs: through the local FS/APA/AMNP/AME; for the local aviation unit commander.

Table 6–1
Number of months for which a flying duty medical examination is valid (Active Component)*

Month in which last FDME was given												
Birth Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jan	12	11	10	9	8	7	18	17	16	15	14	13
Feb	13	12	11	10	9	8	7	18	17	16	15	14
Mar	14	13	12	11	10	9	8	7	18	17	16	15
Apr	15	14	13	12	11	10	9	8	7	18	17	16
May	16	15	14	13	12	11	10	9	8	7	18	17
Jun	17	16	15	14	13	12	11	10	9	8	7	18
Jul	18	17	16	15	14	13	12	11	10	9	8	7
Aug	7	18	17	16	15	14	13	12	11	10	9	8
Sep	8	7	18	17	16	15	14	13	12	11	10	9
Oct	9	8	7	18	17	16	15	14	13	12	11	10
Nov	10	9	8	7	18	17	16	15	14	13	12	11
Dec	11	10	9	8	7	18	17	16	15	14	13	12

Note:

[1] Read down the left column to the examinee's birth month; read across to month of last FDME; intersection number is the maximum validity period. When last FDME was within the 3-month period preceding the end of the birth month, the validity period will normally not exceed 15 months. When the last FDME was for entry into aviation training, for FEB, postaccident, posthospitalization, pre-appointment (warrant officer candidate) etc., the validity period will range from 7 to 18 months. Validity periods may be extended, in accordance with 6–11i, by 1 month only for completion of an examination begun before the end of the birth month.

Chapter 7
Physical Profiling

7–1. General
This chapter prescribes a system for classifying individuals according to functional abilities. Also see paragraphs 3–12, 3–13, 3–25, 3–27, 3–30, 3–45, and 3–46 for additional guidance on amputations, coronary artery disease, asthma, seizure disorders, and heat and cold injuries.

7–2. Application
The physical profile system is applicable to the following categories of personnel:

a. Registrants who undergo an induction or pre-induction medical examination related to Selective Service processing.

b. All applicants examined for enlistment, appointment, or induction.

c. Members of any component of the U.S. Army throughout their military Service, whether or not on active duty.

7–3. Physical profile serial system
a. The physical profile serial system is based primarily upon the function of body systems and their relation to military duties. The functions of the various organs, systems, and integral parts of the body are considered. Since the analysis of the individual's medical, physical, and mental status plays an important role in assignment and welfare, not only must the functional grading be executed with great care, but clear and accurate descriptions of medical, physical, and mental deviations from normal are essential.

b. In developing the system, the functions have been considered under six factors designated "P–U–L–H–E–S." Four numerical designations are used to reflect different levels of functional capacity. The basic purpose of the physical profile serial is to provide an index to overall functional capacity. Therefore, the functional capacity of a particular organ or system of the body, RATHER THAN THE DEFECT PER SE, will be evaluated in determining the numerical designation 1, 2, 3, or 4.

c. The factors to be considered are as follows:

(1) *P—Physical capacity or stamina.* This factor, general physical capacity, normally includes conditions of the heart; respiratory system; gastrointestinal system, genitourinary system; nervous system; allergic, endocrine, metabolic and nutritional diseases; diseases of the blood and blood forming tissues; dental conditions; diseases of the breast, and other organic defects and diseases that do not fall under other specific factors of the system.

(2) *U—Upper extremities.* This factor concerns the hands, arms, shoulder girdle, and upper spine (cervical, thoracic, and upper lumbar) in regard to strength, range of motion, and general efficiency.

(3) *L—Lower extremities.* This factor concerns the feet, legs, pelvic girdle, lower back musculature and lower spine (lower lumbar and sacral) in regard to strength, range of motion, and general efficiency.

(4) *H—Hearing and ears.* This factor concerns auditory acuity and disease and defects of the ear.

(5) *E—Eyes.* This factor concerns visual acuity and diseases and defects of the eye.

(6) *S—Psychiatric.* This factor concerns personality, emotional stability, and psychiatric diseases.

d. Four numerical designations are assigned for evaluating the individual's functional capacity in each of the six factors. Guidance for assigning numerical designators is contained in table 7–1. The numerical designator is not an automatic indicator of "deployability" or assignment restrictions, or referral to an MEB. The conditions listed in chapter 3 and the Soldier's functional limitations, rather than the numerical designator of the profile, will be the determining factors for MEB processing.

(1) An individual having a numerical designation of "1" under all factors is considered to possess a high level of medical fitness.

(2) A physical profile designator of "2" under any or all factors indicates that an individual possesses some medical condition or physical defect that may require some activity limitations.

(3) A profile containing one or more numerical designators of "3" signifies that the individual has one or more medical conditions or physical defects that may require significant limitations. The individual should receive assignments commensurate with his or her physical capability for military duty.

(4) A profile serial containing one or more numerical designators of "4" indicates that the individual has one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited.

e. Anatomical defects or pathological conditions will not of themselves form the sole basis for recommending assignment or duty limitations. While these conditions must be given consideration when accomplishing the profile, the prognosis and the possibility of further aggravation must also be considered. In this respect, profiling officers must consider the effect of their recommendations upon the Soldier's ability to perform duty. Profiles must be realistic. All profiles and assignment limitations must be specific, and written in lay terms. If the commander has questions about a profile or is unable to use the Soldier within the profile limitations, the procedures in paragraph 7–12 will apply.

(1) Determination of individual assignment or duties to be performed is a commander's decision. Limitations such as "no field duty," or "no overseas duty," are not proper medical recommendations. (However, they are included as administrative guidelines in pregnancy profiles.) Profiling officers will provide enough information regarding the Soldier's physical limitations to enable the nonmedical commander and AHRC to make a determination on individual assignments or duties. The profiling officer is responsible for entering the correct administrative code from table 7–2 into Item 2 of the DA Form 3349.

(2) It is the responsibility of the commander or personnel management officer to determine proper assignment and duty, based upon knowledge of the Soldier's profile, assignment limitations, and the duties of their grade and MOS.

(3) The commander has the final decision on the deployment of Soldiers in his/her unit. When medical providers and commanders disagree on the medical readiness status of a Soldier, the decision will be raised to the first general officer in the Soldier's chain of command, who will review both medical and commander recommendations and make the final decision whether to deploy the Soldier.

(4) Table 7–1 contains the physical profile functional capacity guide.

(5) See TB MED 287 for profiling Soldiers with pseudofolliculitis.

7–4. Temporary vs. permanent profiles

a. *Electronic requirements.* All temporary profiles greater than 30 days and all permanent profiles must be completed electronically. There are two ways to access the electronic profile; one through AHLTA (Version 3.3.2), and one through MODS.

(1) *AHLTA.* Providers first sign into AHLTA and then select the "Medical Readiness" link in AHLTA. From the Medical Readiness portal, the provider then selects the link for the e-Profile.

(2) *MODS.* Providers can also access the e-Profile application at: https://apps.mods.army.mil.

Note.

If the electronic systems are unavailable, the provider will issue a temporary profile in paper form for 30 days duration until the profile can be entered into e-Profile.

b. *Permanent profiles.* A profile is considered permanent unless a modifier of "T" (temporary) is added. A permanent profile may only be awarded or changed by the authority designated in paragraph 7–6, below. All permanent "3" and "4" profiles, for Soldiers on active duty, will be reviewed by an MEB physician or physician approval authority. An MEB physician is an MTF dedicated subject matter expert trained to perform disability evaluations per guidelines established in DODI 1332.38 (see AR 40–400 for MEB process). The MEB physician will assist the MTF commander in educating profiling officers on current physical profiling regulation and policy guidance.

(1) If the profile is permanent, the profiling officer must assess if the Soldier meets the medical retention standards of chapter 3. Those Soldiers on active duty who do not meet the medical retention standards must be referred to an MEB as per chapter 3. (See paras 9–10 and 10–25, respectively, for disposition of USAR and ARNG Soldiers not on active duty who do not meet medical retention standards.)

(2) Soldiers who have one or more condition(s) that do not meet medical retention standards are referred to a MEB /PEB after attaining the Medical Retention Determination Point (MRDP). The MRDP is when the Soldier's progress appears to have medically stabilized; the course of further recovery is relatively predictable; and where it can be reasonably determined that the Soldier is most likely not capable of performing the duties required of his MOS, grade, or rank. This MRDP and referral to a MEB/PEB will be made within 1 year of being diagnosed with a medical condition(s) that does not appear to meet medical retention standards, but the referral may be earlier if the medical provider determines that the Soldier will not be capable of returning to duty within 1 year. The MEB physician or physician approval authority will review all MEB referrals to insure that MRDP has been achieved prior to initiating a medical evaluation board; coordinate inappropriate MEB referrals back through the profiling officer for appropriate disposition; and assist physician approving authorities in reconciling profiling officer's questions and concerns about MRDP timing and MMRB versus MEB referrals. The MEB physician or physician approval authority will review all profiles to confirm that the MRDP has been reached before obtaining the approving authority signature.

(3) Those Soldiers (active duty and USAR/ARNG) who meet retention standards but have at least a 3 or 4 PULHES serial will be referred to a Medical MOS Retention Board (MMRB) in accordance with AR 600–60, unless waived by the MMRB convening authority.

(4) Permanent profiles may be amended (following the correct procedure) at any time if clinically indicated and will automatically be reviewed and verified by the privileged provider at the time of a Soldier's periodic health assessment or other medical examination.

(5) The Soldier's commander may also request a review of a permanent profile, in accordance with paragraph 7–12*b*.

c. *Temporary profiles.* Soldiers receiving medical or surgical care or recovering from illness, injury, or surgery, will be managed with temporary physical profiles until they reach the point in their evaluation, recovery, or rehabilitation where the profiling officer determines that MRDP has been achieved but no longer than 12 months. A temporary profile is given if the condition is considered temporary, the correction or treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. Soldiers on active duty and RC Soldiers not on active duty with a temporary profile will be medically evaluated at least once every 3 months at which time the profile may be extended for a maximum of 6 months from the initial profile start date by the profiling officer.

(1) Temporary profiles exceeding 6 months duration, for the same medical condition, will be referred to a specialist (for that medical condition) for management and consideration for one of the following actions:

(a) Continuation of a temporary profile for a maximum of 12 months from the initial profile start date;

(b) Change the temporary profile to a permanent profile;

(c) Determination of whether the Soldier meets the medical retention standards of chapter 3 and, if not, referral to an MEB.

(2) The profiling officer must review previous profiles before making a decision to extend a temporary profile and refer the Soldier to a medical specialist for management if the temporary profile has been in effect for 6 months. Any extension of a temporary profile must be recorded on DA Form 3349, and if renewed, item 8 on the DA Form 3349 will contain the following statement: "This temporary profile is an extension of a temporary profile first issued on (date)."

(3) Temporary profiles will specify an expiration date. If no date is specified, the profile will automatically expire at the end of 30 days from issuance of the profile. In no case will Soldiers carry a temporary profile that has been extended for more than 12 months. If a profile is needed beyond the 12 months, the temporary profile will be changed to a permanent profile. Exceptions to the 12-month temporary physical profile restriction must be approved by the medical treatment facility (MTF) commander or their designated senior physician approval authority (often the deputy commander for clinical services).

7–5. Representative profile serial and codes

To facilitate the assignment of individuals after they have been given a physical profile serial and for statistical purposes, code designations have been adopted to represent certain combinations of physical limitations or assignment guidance (see table 7–2, below). The alphabetical coding system will be recorded on the DA Form 3349, item 2 and personnel qualifications records. Up to three different codes can be listed in item 2. This coding system will not be used on medical records to identify limitations. The numerical designations under each profile factor, PULHES, are given in table 7–1, below.

7–6. Profiling officer and approving authority

a. *Profiling officers.* Commanders of Army MTFs are authorized to designate one or more physicians, dentists, optometrists, podiatrists, audiologists, nurse practitioners, nurse midwives, licensed clinical psychologists, and physician assistants as profiling officers. The commander will assure that those designated are thoroughly familiar with the contents of this regulation. Profiling officer limitations are as follows:

(1) *Physicians.* No limitations except for temporary profiles that exceed 6 months that require referral to a specialist (see para 7–4*c*(1)).

(2) *Dentists, optometrists, physical therapists, chiropractors, and occupational therapists.* No limitation within their specialty for awarding temporary or permanent numerical designators "1" and "2." A temporary numerical designator "3" may be awarded for a period not to exceed 90 days. Any extension beyond 90 days must be signed by a physician. (See para 7–8.)

(3) *Audiologists.* No limitation within their specialty for awarding permanent numerical designators "1," "2," "3," or "4" in cases of sensorineural hearing loss, if retrocochlear lesion has been ruled out. Changing from or to a permanent numerical designator "3" or "4" requires the co-signature of a physician approving authority (see para 7–8).

(4) *Physician assistants, nurse midwives, nurse practitioners, and licensed clinical psychologists.* Limited to awarding temporary numerical designators "2," "3," and "4" for a period not to exceed 90 days. Any extension of a temporary profile beyond 90 days must be signed by a physician, except when the provisions of paragraph 7–9 apply. However, physician assistants with AOC 65DM1 certified in orthopedics have no limitations in awarding temporary orthopedic profiles or permanent profiles with a numerical designator of "1" or "2." Physician assistants, nurse midwives, nurse practitioners, and licensed clinical psychologists may award permanent profiles of "2", "3," or "4" provided the profile is signed by the physician approving authority.

(5) *Podiatrists.* No limitations within their specialty for awarding temporary or permanent profiles with a numerical designator of "1" or "2." Podiatrists may award permanent profiles of "3" or "4" providing the profile is signed by a physician approving authority.

(6) *MEPS physicians, physician assistants, and nurse practitioners.* They will also be designated as profiling officers. (See para 7–7*b*.)

(7) *Other DOD physicians.* In those instances where a Soldier does not have access to an Army MTF, but is assigned to a location with another Department of Defense medical facility (Navy, Air Force), a physician from another Service can be a profiling officer, if designated by the commander.

(8) *AD TRICARE Prime Remote Soldiers, Selected Reserve (TPU, AGR, IMA) and ARNG Soldiers.* These Soldiers may have profiles completed via the current agencies contracted to provide these medical services.

b. *Approving authority.* Commanders of Army MTFs are authorized to designate or delegate one or more physicians as approving authorities. The commander will assure that those designated are thoroughly familiar with the contents of this regulation. The approving authority must be a physician. Permanent "3" or "4" physical profiles require an approving authority signature.

7–7. Recording and reporting of initial physical profile

a. Individuals accepted for initial appointment, enlistment, or induction in peacetime normally will be given a numerical designator "1" or "2" physical profile in accordance with the instructions contained in this regulation. Initial physical profiles will be recorded on DD Form 2808 by the medical profiling officer at the time of the initial appointment, enlistment, or induction medical examination.

b. The initial physical profile serial will be entered on DD Form 2808 and also recorded on DD Forms 1966 (Record of Military Processing—Armed Forces of the United States), in the appropriate spaces. When the modifier "T" is entered on the profile serial, or in those exceptional cases where the numerical designator "3" is used on initial entry, a brief, nontechnical description of the defect will be recorded in the "Summary of Defects" section on the DD Form 2808, in addition to the exact diagnosis. All physical, geographic, or climatic area limitations applicable to the defect will also be entered in that section. If sufficient room for a full explanation is not available in that section, proper reference will be made in that section number and an additional sheet of paper attached. It is not uncommon for the MEPS to assign a profile with the numerical designator of "3" or "0" pending a medical waiver review of a disqualifying condition. This is for their administrative purposes only. If the individual receives a medical waiver, the waiver documentation completed by the waiver authority should indicate the appropriate profile in accordance with table 7–1.

7–8. Profiling reviews and approvals

a. Permanent "3" or "4" profiles require the signatures of 2 profiling officers, one of which is a physician approving authority (unless the provisions of 7–8*f* apply). (Permanent profiles of "3" or "4" for the Individual Ready Reserve are valid with only one signature if signed by the AHRC Surgeon or his/her designee.) (ANG requires the signatures of 2 profiling

officers for all permanent profiles to include permanent “1” or “2.” See para 10–12). Temporary or permanent profiles of “1” or “2” require the signature of one profiling officer. See paragraph 7–6 to determine who is authorized to sign profiles.

b. Situations that require a mandatory review of an existing physical profile include—

(1) Return to duty of a Soldier hospitalized. The attending physician will ensure that the patient has the correct physical profile, assignment limitations(s), and medical followup instructions, as appropriate.

(2) When directed by the appointing authority in cases of a problematical or controversial nature requiring temporary revision of profile.

(3) At the time of the periodic health assessment or other medical examination.

(4) Upon request of the unit commander.

(5) On request of a PEB.

(6) When a permanent “3” or “4” profile is changed to a permanent “1” or “2” the change requires the signatures of 2 profiling officers, one of which is a physician approving authority (unless the provisions of 7–8*f*apply).

c. A temporary revision of profile will be completed when, in the opinion of the profiling officer, the functional capacity of the individual has changed to such an extent that it temporarily alters the individual's ability to perform duty. Temporary profiles written on DA Form 3349 will not exceed 3 months except as provided for in paragraphs 7–8*d* and 7–9. Temporary profiles written on DD Form 689 (Individual Sick Slip) will not exceed 30 days.

d. Tuberculous patients returned to a duty status who require anti-tuberculous chemotherapy following hospitalization will be given a temporary “2” profile under the P factor of the physical profile for a period of 1 year with recommendation that the Soldier be placed on duty at a fixed installation and will be provided the required medical supervision for a period of 1 year.

e. The physical profile in controversial or equivocal cases may be verified or revised by the hospital commander or command surgeon.

f. Physical profiles for Reserve Soldiers not on active duty and for those Soldiers activated on orders for greater than 30 days in the Ready Reserve (ARNG/AR), Standby Reserve (AR), and Retired Reserve (AR), may be accomplished by the U.S. Army Regional Support Command (RSC) surgeons, division staff surgeons, Active Army medical facility profiling officers (Reserve Soldiers on orders for 30 days or greater only), USAR/ARNG contracted agencies profiling officers, the U.S. Army Reserve (USARC) command surgeon and the AHRC command surgeon or their designees (Ready Reserve only). For ARNG/ARNGUS Soldiers not on active duty, profiles will be accomplished by State ARNG/ARNGUS providers. The respective State surgeons (if physician) or their designated physician alternate can be the approving authority for permanent "3" or "4" profiles. The NGB chief surgeon is also an ARNG approval authority for all ARNG Soldiers. The ARNG division surgeons may be designated as approval authority, but would require delegation by each concerned State or Territory State surgeon. Approval authorities for the Army Reserve are the USARC command surgeon and the Regional Support Command surgeons. The USAR operational and functional command surgeons and division surgeons that function as command surgeons may be delegated profile-approving authority by the USARC command surgeon.

g. Individuals who were found unfit by a PEB but COAD used to be assigned a code “V” on their physical profile code. The code “V” is no longer used for this purpose but rather to identify Soldiers with restrictions on deployment. An “X” is now used to identify individuals who were found unfit by a PEB but COAD or COAR.

h. MEB physicians must ensure that all physical profile and assignment limitations are fully recorded on one DA Form 3349. When the Soldier is referred to a PEB, a copy of the consolidated DA Form 3349 will be forwarded to the PEB with the MEB proceeding, with distribution of the form as indicated in paragraph 7–11*b*, below. On the consolidated DA Form 3349, the MEB physician may be the profiling officer (1st signature). Cooperation between the MEB physician, PEB liaison officers, and the PEB is essential when additional medical information or profile reconsideration is requested from the MTF by the PEB. The limitations described on the profile form may affect the decision of fitness by the PEB.

i. Table 7–1 will be used when determining the numerical designator of the PULHES factors. (For example, a Soldier will not be given a permanent “3” or “4” solely on the basis of a referral to a PEB.)

7–9. Profiling pregnant Soldiers

a. *Intent.* The intent of these provisions is to protect the fetus while ensuring productive use of the Soldier. Common sense, good judgement, and cooperation must prevail between policy, Soldier, and Soldier's commander to ensure a viable program. This profile has been revised from the previous profile published in the 1995 edition of this regulation. This profile guidance has been revised and includes mandating an occupational health interview to assess risks to the Soldier and fetus and adding additional restrictions to reduce exposure to solvents, lead, and fuels that may be associated with adverse pregnancy outcomes.

b. *Responsibilities.*

(1) *Soldier.* The Soldier will seek medical confirmation of pregnancy and will comply with the instructions of medical personnel and the individual's unit commander.

(2) *Medical personnel.* A privileged provider (physician, nurse midwife/practitioner or physician assistant) will confirm pregnancy and once confirmed will initiate prenatal care of the Soldier and issue a physical profile. Nurse midwives, nurse practitioners, and physician assistants are authorized to issue routine or standard pregnancy profiles for the duration of the pregnancy. An occupational history will be taken at the first visit to assess potential exposures related to the Soldier's specific MOS. This history is ideally taken by the occupational medicine physician or nurse. However, if this is not feasible, the profiling officer must complete the occupational history. After review of the occupational history, the profiling officer (physician, nurse midwife/practitioner, or physician assistant), in conjunction with the occupational health clinic as needed, will determine whether any additional occupational exposures, other than those indicated in the paragraphs below, should be avoided for the remainder of the pregnancy. Examples include but are not limited to hazardous chemicals, ionizing radiation, and excessive vibration. If the occupational history or industrial hygiene sampling data indicate significant exposure to physical, chemical, or biological hazards, then the profile will be revised to restrict exposure from these workplace hazards.

(3) *Unit commander.* The commander will counsel all female Soldiers as required by AR 600–8–24 or AR 635–200. The unit commander will consult with medical personnel as required. This includes establishing liaison with the occupational health clinic and requesting site visits by the occupational health personnel if necessary to assess any work place hazards.

c. Physical profiles.

(1) Profiles will be issued for the duration of the pregnancy. The MTF will ensure that the unit commander is provided a copy of the profile, and advise the unit commander as required. Upon termination of pregnancy, a new profile will be issued reflecting revised profile information. Physical profiles will be issued as follows:

(2) Under factor "P" of the physical profile, indicate "T–3."

(3) List diagnosis as "pregnancy, estimated delivery date."

d. Limitations. Unless superceded by an occupational health assessment, the standard pregnancy profile, DA Form 3349, will indicate the following limitations:

(1) Except under unusual circumstances, the Soldier should not be reassigned to overseas commands until pregnancy is terminated. (See AR 614–30 for waiver provisions and for criteria curtailing OCONUS tours.) She may be assigned within CONUS. Medical clearance must be obtained prior to any reassignment.

(2) The Soldier will not receive an assignment to duties where nausea, easy fatigue, or sudden lightheadedness would be hazardous to the Soldier, or others, to include all aviation duty, Classes 1/2/3. (However, there are specific provisions in para 4–13*c* that allow the aircrew member to request and be granted permission to remain on flight status. ATC personnel may continue ATC duties with approval of the flight surgeon, obstetrician, and ATC supervisor.)

(3) Restrict exposures to military fuels. Pregnant Soldiers must be restricted from assignments involving frequent or routine exposures to fuel vapors or skin exposure to spilled fuel such as fuel handling or otherwise filling military vehicles with fuels such as mogas, JP8, and JP4.

(4) No weapons training in indoor firing ranges due to airborne lead concentrations and bore gas emissions. Firing of weapons is permitted at outdoor sites. (See (11) below, for other weapons training restrictions.) No exposure to organic solvent vapors above permissible levels. (For example, work in ARMS room is permitted if solvents are restricted to 1999 MIL–PRF–680, degreasing solvent.)

(5) No work in the motor pool involving painting, welding, soldering, grinding, and sanding on metal, parts washing, or other duties where the Soldier is routinely exposed to carbon monoxide, diesel exhaust, hazardous chemicals, paints, organic solvent vapors, or metal dusts and fumes (for example, motor vehicle mechanics). It does not apply to pregnant Soldiers who perform preventive maintenance checks and services (PMCS) on military vehicles using impermeable gloves and coveralls, nor does it apply to Soldiers who do work in areas adjacent to the motor pool bay (for example, administrative offices) if the work site is adequately ventilated and industrial hygiene sampling shows carbon monoxide, benzene, organic solvent vapors, metal dusts and fumes do not pose a hazard to pregnant Soldiers. (See (11), below, for PMCS restrictions at 20 weeks of pregnancy.)

(6) The Soldier must avoid excessive vibrations. Excessive vibrations occur in larger ground vehicles (greater than 1 1/4 ton) when the vehicle is driven on unpaved surfaces.

(7) Upon the diagnosis of pregnancy, the Soldier is exempt from regular unit physical fitness training and APFT testing/weight standards for the duration of the pregnancy and 180 days past pregnancy termination. After receiving medical clearance from their health care provider to participate in physical training, commanders will enroll Soldiers who are pregnant or postpartum to take part in the Army Pregnancy/Postpartum Physical Training (PPPT) program, an element of the Army Physical Fitness Training Program, in accordance with AR 350–1, Army Training and Education. The PPPT Program is designed to maintain health and fitness levels of pregnant Soldiers, and successfully integrate postpartum Soldiers back into unit physical fitness training programs with emphasis on achieving the APFT standards in accordance with guidance provided in the Army Physical Fitness Training Program, and meeting height/weight standards in accordance

with guidance provided in the Army Weight Control Program. Pregnant and postpartum Soldiers must be cleared by their health care provider prior to participating in physical fitness training. Once pregnancy has been confirmed, the Soldier is exempt from wearing load bearing equipment (LBE) to include the web belt, individual body armor (IBA) and/or any other additional equipment. Wearing of individual body armor and/or any other additional equipment is not recommended and must be avoided after 14 weeks gestation.

(8) The Soldier is exempt from all immunizations except influenza and tetanus-diphtheria and from exposure to all fetotoxic chemicals noted on the occupational history form. The Soldier is exempt from exposure to chemical warfare and riot control agents (for example, nuclear, biological, and chemical training) and wearing MOPP gear at any time.

(9) The Soldier may work shifts.

(10) The Soldier must not climb or work on ladders or scaffolding.

(11) At 20 weeks of pregnancy, the Soldier is exempt from standing at parade rest or attention for longer than 15 minutes. The Soldier is exempt from participating in swimming qualifications, drown proofing, field duty, and weapons training. The Soldier must not ride in, perform PMCS on, or drive in vehicles larger than light medium tactical vehicles due to concerns regarding balance and possible hazards from falls.

(12) At 28 weeks of pregnancy, the Soldier must be provided a 15-minute rest period every 2 hours. Her workweek should not exceed 40 hours and the Soldier must not work more than 8 hours in any 1 day. The 8-hour work day does include one hour for physical training (PT) and the hours worked after reporting to work or work call formation, but does not include the PT hygiene time and travel time to and from PT.

e. *Performance of duty.* A woman who is experiencing a normal pregnancy may continue to perform military duty until delivery. Only those women experiencing unusual and complicated problems (for example, pregnancy-induced hypertension) will be excused from all duty, in which case they may be hospitalized or placed sick in quarters. Medical personnel will assist unit commanders in determining duties.

f. Sick in quarters. A pregnant Soldier will not be placed sick in quarters solely on the basis of her pregnancy unless there are complications present that would preclude any type of duty performance.

7–10. Postpartum profiles

a. Convalescent leave (as prescribed by AR 600–8–10) after delivery will be for a period determined by the attending physician. This will normally be for 42 days following normal pregnancy and delivery.

b. Convalescent leave after a termination of pregnancy (for example, miscarriage) will be determined on an individual basis by the attending physician.

c. Prior to commencing convalescent leave, postpartum Soldiers will be issued a postpartum profile. The temporary profile will be for 45 days. It begins on the day of child birth or termination of pregnancy and will allow PT at the Soldier's own pace. Soldiers are encouraged to use the AT-Home component of the ARMY PPPT Program while on convalescent leave. If a Soldier decides to return early from convalescent leave, the temporary profile remains in effect for the entire 45 days.

d. Soldiers will receive clearance from the profiling officer to return to full duty.

e. Postpartum (any pregnancy that lasts 20 weeks and beyond) Soldiers, in accordance with DODD 1308.1, are exempt from the APFT and from record weigh-in for 180 days following termination of pregnancy. After receiving clearance from their health care provider to resume physical fitness training, postpartum Soldiers will take part in the postpartum physical fitness training element of the Army. Postpartum Soldiers must receive clearance from their health care provider prior to returning to regular unit physical fitness training if it is before 180 days following pregnancy termination. After receiving clearance from their physician to resume physical training, they are expected to use the time in preparation for the APFT.

f. The above guidance will only be modified if, upon evaluation of a physician, it has been determined the postpartum Soldier requires a more restrictive or longer profile because of complicated or unusual medical problems.

7–11. Preparation, approval, and disposition of DA Form 3349

a. *Preparation of DA Form 3349.*

(1) The DA Form 3349 will be used to record both permanent profiles and temporary profiles. The DA Form 689 (Individual Sick Slip) may be used in lieu of DA Form 3349 for temporary profiles not to exceed 30 days and will include information on activities the Soldier can perform, as well as the physical limitations. An SF 600 will be used to attach additional information to the DA Form 3349 on the physical activities a Soldier can or cannot perform if there is inadequate space on the DA Form 3349. This additional SF 600 will be clearly labeled as a continuation of the DA Form 3349.

(2) If electronic profiling is available, an electronic DA Form 3349 will be used for all profiles over 30 days duration.

(3) The DA Form 3349 will be prepared as follows:

(a) Item 1. Record medical conditions and/or physical defects in common usage, nontechnical language that a layman can understand. For example, “compound comminuted fracture, left tibia” might simply be described as “broken leg.” The

checkboxes labeled Injury and Illness/Disease are used for tracking purposes. Check the injury box if the Soldier's medical condition is the result of an injury; otherwise, check the box labeled Illness/Disease.

(b) Item 2. Code designations (defined in table 7–2) are limited to permanent profiles for administrative use only and are to be completed by the profiling officer. Up to three different codes can be listed. All functional and assignment limitations are recorded in item 8.

(c) Item 3. Enter under each permanent and temporary PULHES factors the appropriate profile serial code (1, 2, 3, and 4) as prescribed) for the specific PULHES factor. A Soldier may have a permanent profile for one condition and a temporary profile for another. All permanent profile blocks must be filled in. Only the applicable block under the temporary profile needs to be completed. For example, a Soldier with a sprained ankle who has permanent H3 hearing loss would be coded 111311 in the permanent PULHES space but _ _ 3 _ _under the temporary PULHES space.

(d) Item 4. Profile type. Check the appropriate block "a" or "b" for the type of profile. If the profile is temporary, enter the expiration date. If the profile is permanent, the profiling officer must assess if the Soldier meets retention standards of chapter 3 (Item 7).

(e) Item 5. Answer "Yes" or "No" to items 5a through 5j. These functional activities are the minimum requirements to be considered medically qualified for military duties worldwide and under field conditions. If any answer is "No" then the appropriate profile serial will in most cases be at least a 3 and the Soldier will be referred to a MEB. If the Soldier is able to do all the functional activities listed in 5 and meets the retention standards of chapter 3, the Soldier will be referred to a MMRB in accordance with AR 600–60, unless waived by the MMRB convening authority.

(f) Item 6. Physical Fitness Test. Check either "Yes" or "No" to indicate whether the Soldier can perform the activities for the APFT. The "Yes" or "No" blocks on the alternate APFT need only be completed if the Soldier has restrictions for the regular APFT. If the Soldier cannot perform at least an alternate APFT the profile serial will be at least a 3 and referred to an MEB.

(g) Item 7. Those Soldiers (active duty and USAR/ARNG) who meet retention standards but have at least a permanent 3 or 4 PULHES (yes for item 7) serial will be referred to a MMRB in accordance with AR 600–60, unless waived by the MMRB convening authority. Those Soldiers on active duty who do not meet retention standards ("No" for item 7), must be referred to an MEB as per chapter 3. (See paras 9–10 and 10–26 for disposition of USAR and ARNG Soldiers not on active duty who do not meet medical retention standards.)

(h) Item 8. This space will be used to list any other physical activity restrictions or limitations not listed elsewhere on the form. In accordance with paragraph 7–4*b*, the profiling officer must review previous profiles before making a decision to extend a temporary profile. If this is an extension of a previous temporary profile, fill in the date of the original temporary profile in Item 8.

(i) Items 9, 10, and 11. Name and signature of profiling officer and date profile completed. Print name, grade and title of profiling officer, signature, and date. Permanent "1" or "2" profiles require the signature of one profiling officer. The signature of the profiling officer for "1" or "2" profiles is written in the section: "Typed name, grade, and title of profiling officer." Permanent "3" or "4" profiles require the signatures of two profiling officers, one of whom is the physician approving authority (unless the provisions of 7–8*f* apply). (See para 7–8 to determine who is qualified to be a profiling officer.) Temporary profiles require only the signature of one profiling officer except for extensions of profiles noted in paragraph 7–6*a*(2).

(j) Items 12, 13, and 14. Name and signature of approving authority and date reviewed. The approving authority will be designated by the MTF commander. (In the case of RC Soldiers not on active duty, see para 7–8*f*.) The approving authority for permanent "3" or "4" profiles must be a physician. If the approving authority does not concur with the profiling officer recommendation, the MTF commander will make the final decision.

(k) Item 15. How to access electronic profiles on Soldiers. Commanders can access the electronic profiles of Soldiers in their unit by going to http://www.mods.army.mil/ and clicking on "e-Profile" in MODS in the list of applications. Commanders are required to register and be approved to access the e-Profile module in MODS before they can gain access to the electronic profiles

(l) Item 16. Include patient identification: Name (Last, First); Grade/Rank; SSN (last 4 numbers or SSN); and the Soldier's unit.

(m) Item 17. Hospital or Medical facility.

(n) Item 18. Profiling Officer E-mail.

b. Disposition of DA Form 3349 (temporary or permanent) by the MTF. The electronic profile will be routed to the military personnel office (MILPO) and the Soldier's medical record. A paper copy of DA Form 3349 will be given to the Soldier. If the e-Profile is not available, a paper copy will be delivered by means other than the individual on whom the report is made to the following:

(1) Original to the Soldier's health record.

(2) One copy to the Soldier's commander.

(3) One copy to the MILPO.

c. *Medical Protection System.* The profiling officer (or approving authority if applicable) is responsible for ensuring the PULHES and Date of Profile is entered into the Medical Protection System (MEDPROS).

7–12. Responsibility for personnel actions

a. Commanders and personnel officers are responsible for necessary personnel actions, including appropriate entries on personnel management records and the assignment of the individual to military duties commensurate with the individual's physical profile and recorded assignment limitations.

b. If the Soldier's commander believes the Soldier cannot perform within the limits of the permanent profile, the commander will request reconsideration of the profile by the profiling physician. Reconsideration must be accomplished by the profiling officer, who will either amend the profile or revalidate the profile as appropriate. Commanders may also request a review of temporary profiles.

7–13. Physical profile and the Army Weight Control Program

The DA Form 3349 will not be used to excuse Soldiers from the provisions of AR 600–9. The AR 600–9 contains a standard memorandum for completion by a physician if there is an underlying or associated disease process that is the cause of the overweight condition. The inability to perform all APFT events or the use of certain medications is not generally considered sufficient medical rationale to exempt a Soldier from AR 600–9.

Table 7–1
Physical profile functional capacity guide

Profile **Serial**	**P** **Physical capacity**	**U** **Upper extremities**	**L** **Lower extremities**	**H** **Hearing–ears**	**E** **Vision–eyes**	**S** **Psychiatric**
Factors to be considered.	Organic defects, strength, stamina, agility, energy, muscular coordination, function, and similar factors.	Strength, range of motion, and general efficiency of upper arm, shoulder girdle, and upper back, including cervical and thoracic vertebrae.	Strength, range of movement, and efficiency of feet, legs, lower back and pelvic girdle.	Auditory sensitivity and organic disease of the ears	Visual acuity, and organic disease of the eyes and lids.	Type severity, and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external precipitating stress. Predisposition as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorder impairment of functional capacity
1	Good muscular development with ability to perform maximum effort for indefinite periods.	No loss of digits or limitation of motion; no demonstrable abnormality; able to do hand to hand fighting.	No loss of digits or limitation of motion; no demonstrable abnormality; able to perform long marches, stand over long periods, run.	Audiometer average level for each ear not more than 25 dB at 500, 1000, 2000 Hz with no individual level greater then 30 dB. Not over 45 dB at 4000 Hz.	Uncorrected visual acuity 20/200 correctable to 20/20, in each eye.	No psychiatric pathology. May have history of a transient personality disorder.
2	Able to perform maximum effort over long periods.	Slightly limited mobility of joints, muscular weakness, or other musculo-skeletal defects that do not prevent hand–to–hand fighting and do not disqualify for prolonged effort.	Slightly limited mobility of joints, muscular weakness, or other musculo-skeletal defects that do not prevent moderate marching, climbing, timed walking, or prolonged effort.	Audiometer average level for each ear at 500, 1000, 2000 Hz, ***or*** not more than 30 dB, with no individual level greater than 35 dB at these frequencies, and level not more than 55 dB at 4000 Hz; ***or*** audiometer level 30 dB at 500 Hz, 25 dB at 1000 and 2000 Hz, and 35 dB at 4000 Hz in better ear. (Poorer ear may be deaf.)	Distant visual acuity correctable to not worse than 20/40 and 20/70, or 20/30 and 20/100, or 20/20 and 20/400.	May have history of recovery from an acute psychotic reaction due to external or toxic causes unrelated to alcohol or drug addiction.

Table 7–1
Physical profile functional capacity guide—Continued

Profile Serial	P Physical capacity	U Upper extremities	L Lower extremities	H Hearing–ears	E Vision–eyes	S Psychiatric
3	Unable to perform full effort except for brief or moderate periods.	Defects or impairments that require *significant* restriction of use.	Defects or impairments that require *significant* restriction of use.	Speech reception threshold in best ear not greater than 30 dB HL, measured with or without hearing aid; or acute or chronic ear disease.	Uncorrected distant visual acuity of any degree that is correctable not less than 20/40 in the better eye.	Satisfactory remission from an acute psychotic or neurotic episode that permits utilization under specific conditions (assignment when outpatient psychiatric treatment is available or certain duties can be avoided).
4	*Functional level below P3.*	*Functional level below U3.*	*Functional level below L3.*	*Functional level below H3.*	*Visual acuity below E3.*	Does not meet S3 above.

Table 7–2
Profile codes*.

Code	Description/assignment limitation	Medical criteria (examples)
CODE A	No assignment limitation.	No demonstrable anatomical or physiological impairment within standards established in table 7–1.
CODE B	Soldier has minor impairments that may disqualify for certain MOS training or assignment.	Minimal loss of joint motion, visual and hearing loss
CODES D through N	Possesses impairments that limit functions or assignments. *The codes listed below are for military personnel administrative purposes. Corresponding limitations are general guidelines and are not to be taken as verbatim limitations. (For example, a Soldier with a code D may not be able to run but may have no restrictions on marching or standing.) Item 8 of DA Form 3349 will contain the specific limitations.*	
CODE D	No strenuous physical activity.	Organic cardiac disease, pulmonary insufficiency.
CODE E	No continuous consumption of combat rations.	Endocrine disorders—recent or repeated peptic ulcer activity—chronic gastrointestinal disease requiring dietary management.
CODE F	No assignment or deployment to OCONUS areas where definitive medical care for the Soldier's medical condition is not available.	Individuals who require continued medical supervision with hospitalization or frequent outpatient visits for serious illness or injury.
CODE H	No duty where sudden loss of consciousness would be dangerous to self or to others such as work on scaffolding, vehicle driving, or near moving machinery.	Seizure disorders; other disorders producing syncopal attacks of severe vertigo, such as Ménierè's syndrome.
CODE J	• Given known handicaps associated with high frequency hearing loss similar to this, commanders are highly recommended to make an individual risk assessment of any Soldier with hearing loss that might be tasked to perform duties that require good hearing. For example, localization and detection of friend or foe sounds, scout, point, sentry, forward listening, post/observer, radio/telephone operator (RTO), and so forth. (See DA Pam 40–501, para 2–4, Combat readiness effects.) Hearing protection measures are required to prevent further hearing loss. 1–No exposure to noise in excess of 85 dBA (decibels measured on the A scale) or weapon firing without use of properly fitted hearing protection. Annual hearing test required. • 2– Further exposure to noise is hazardous to health. No duty or assignment to noise levels in excess of 85 dBA or weapon firing (not to include firing for preparation of replacements for overseas movement (POR) qualification	Susceptibility to acoustic trauma.

Table 7–2
Profile codes*—Continued

Code	Description/assignment limitation	Medical criteria (examples)
	or annual weapons qualification with proper ear protection). Annual hearing test required. • 3– No exposure to noise in excess of 85 dBA or weapon firing without use of properly fitted hearing protection. This individual is "deaf" in one ear. Any permanent hearing loss in the good ear will cause a serious handicap. Annual hearing test required. • 4–Further duty requiring exposure to high intensity noise is hazardous to health. No duty or assignment to noise levels in excess of 85 dBA or weapon firing (not to include firing for overseas movement (POR) or weapon firing without use of properly ear protection). No duty requiring acute hearing. A hearing aid must be worn to meet medical fitness standards.	
CODE N	Limitations restricting wearing of combat boots.	Any vascular or skin condition of the feet or legs that, when aggravated by continuous wear of combat boots, tends to develop unfitting ulcers.
CODE S	MEB. Soldier has been determined to meet medical retention standards of Chapter 3 by a Medical Evaluation Board (MEB).	
CODE T	Waiver granted for a disqualifying medical condition/standard for initial enlistment or appointment. The disqualifying medical condition/standard for which a waiver was granted will be documented in the Soldier's accession medical examination.	
CODE U	Soldier has a limitation that needs to be considered Individually as follows: (Briefly define limitation in item 8, comment section.)	Any significant functional assignment limitation not specifically identified elsewhere.
CODE V	Deployment. This code identifies a Soldier with restrictions on deployment to certain areas.	Explanations of condition(s) and specific restrictions are noted in the medical record.
CODE W	MMRB. This Soldier has a permanent 3 or 4 profile who has been evaluated by a MMRB (MOS Medical Review Board) with a recommendation to retain or reclassify and returned to duty.	
CODE X	COAD/COAR. This Soldier is allowed to continue in the military service with a disease, injury, or medical defect that is below medical retention standards, pursuant to a waiver of retention standards under chapter 9 or 10 of this publication, or waiver of unfit finding and continued on active duty or in active Reserve status under AR 635–40.	
CODE Y	Fit for duty. This Soldier has been determined to be fit for duty (not entitled to separation or retirement because of physical disability) after complete processing under AR 635–40.	

Note:

[1] Codes do not automatically correspond to a specific numerical designator of the profile but are based on the general physical/assignment limitations.

Chapter 8
Medical Examinations—Administrative Procedures

8–1. General

(See chap 6 for aviation administration procedures.) This chapter provides—

a. General administrative policies relative to military medical examinations.

b. Requirements for periodic medical examinations and periodic health assessments (PHA), separation, mobilization, and other medical examinations.

c. Policies relative to hospitalization of examinees for diagnostic purposes and use of documentary medical evidence, consultations, and the individual health record.

d. Policies relative to the scope and recording of medical examinations accomplished for stated purposes.

8–2. Applications

The provisions contained in this chapter apply to all medical examinations and PHAs accomplished at U.S. Army medical facilities or accomplished for the U.S. Army.

8–3. Physical fitness

a. Maintenance of physical and medical fitness is an individual military responsibility, particularly with reference to preventable conditions and remediable defects. Soldiers have an obligation to maintain themselves in a state of good physical condition so that they may perform their duties efficiently. Soldiers must seek timely medical advice whenever they have reason to believe that a medical condition or physical defect affects, or is likely to affect, their physical or mental wellbeing, or readiness status. They should not wait until the time of their annual periodic health assessment to make such a condition or defect known. Soldiers are responsible to seek medical care and report such medical care to their unit commanders. This reporting includes civilian health care. Civilian health records documenting a change which may impact their readiness status will be placed in the reserve component Soldier's military health record.

b. Commanders are responsible for ensuring the Soldier’s readiness and medical status is properly documented in the personnel systems and the appropriate follow-up action is taken in regards to the Soldier’s medical or readiness status.

c. The command the Soldier is assigned to is responsible for ensuring that Soldiers complete all medical readiness requirements.

8–4. Consultations

a. The use of specialty consultants, either military or civilian, is authorized in AR 40–400 and AR 601–270/AFR 33–7/MCO P–1100.75A.

b. A consultation will be completed in the case of an individual being considered for military service, including USMA and ROTC, whenever—

(1) Verification, or establishment, of the exact nature or degree of a given medical condition or physical defect is necessary for the determination of the examinee's medical acceptability or unacceptability based on prescribed medical fitness standards; or

(2) It will assist higher headquarters in the review and resolution of a questionable or borderline case; or

(3) The examining physician deems it necessary.

c. A consultation will be accomplished in the case of a Soldier on active duty whenever it is indicated to ensure the proper medical care and disposition of the Soldier.

d. A medical examiner requesting a consultation will routinely furnish the consultant with—

(1) The purpose or reason for which the individual is being examined; for example, enlistment.

(2) The reason for the consultation; for example, persistent tachycardia.

(3) A brief statement on what is desired of the consultant.

(4) Pertinent extracts from available medical records.

e. Reports of consultation will be appended to DD Form 2808 or PHA.

8–5. Distribution of medical reports

a. The original copy of the PHA will be filed as a permanent record in the heath record (AR 40–66), electronic health record (AHLTA), or outpatient treatment record. All IMR items will be documented on the DD Form 2766 and in MEDPROS. (When a bidirectional link is established between MEDPROS and AHLTA, information will be documented exclusively in the Soldier's electronic health record.) Copies may be reproduced from signed copies by any duplicating process that produces legible and permanent copies. Such copies are acceptable for any purpose unless specifically prohibited by the applicable regulation. Distribution of copies will not be made to unauthorized personnel or agencies.

b. DD Form 2808 and DD Form 2807–1—

(1) Are to be used for all remaining military examinations, to include, the cardiovascular screening program and examinations to attend special schools. Previous medical examinations/histories accomplished on Soldiers in accordance with this chapter should be considered valid. DD Form 2807–2 (Medical Prescreen of Medical History Report) is not required for military medical examinations.

(2) A minimum of two copies (both signed) of DD Form 2807–1 and DD Form 2808 will be prepared. One copy of each will be retained by the examining facility. The other copy will be giled as a permanent record in the heath record (AR 40–66) or outpatient treatment record. Special instructions for preparation and distribution of additional copies are contained elsewhere in this chapter or in other regulations dealing with programs involving or requiring medical examinations. Copies may be reproduced from signed copies by any duplicating process that produces legible and permanent copies.

Such copies are acceptable for any purpose unless specifically prohibited by the applicable regulation. Distribution of copies will not be made to unauthorized personnel or agencies.

(3) In the case of general officers (grade O7 and above), the duplicate DD Form 2808 will be forwarded by the examining facility directly to Department of the Army, General Officer Management Office (DACS–GO), 200 Army Pentagon, Washington, DC 20310–0200.

c. In the case of general officers (grade O7 and above), the duplicate PHA form will be forwarded by the examining facility directly to Department of the Army, General Officer Management Office (DACS–GO), 200 Army Pentagon, Washington, DC 20310–0200.

8–6. Documentary medical evidence

a. Documentary medical records and other documents prepared by physicians or other individuals may be submitted by, or on behalf of, an examinee as evidence of the presence, absence, or treatment of a defect or disease, and will be given due consideration by the examiner(s). Submission and use of such documentary medical evidence is encouraged. If insufficient copies are received, copies will be reproduced to meet the needs of *b*and *c*,below.

b. A copy of each piece of documentary medical evidence received will be appended to each copy of the DD Form 2808 or PHA, and a statement to this effect will be made in the Summary of Defects section and cross-referenced by the pertinent item number or in the medical progress note.

c. When a report of consultation or special test is obtained for an examinee, a copy will be attached to each DD Form 2808 or PHA as an integral part of the medical report, and a statement to this effect will be made on the DD Form 2808 or PHA and cross-referenced by the pertinent item number or in the medical progress note.

8–7. Facilities and examiners

a. Physicians may perform medical examinations of any type except where a specific requirement exists for the examination to be conducted by a physician qualified in a specialty. Physician assistants, nurse practitioners, optometrists, audiologists, and podiatrists, properly qualified by appropriate training and experience, may accomplish such phases of the medical examination as are deemed appropriate by the examining physician. They may sign the report of medical examination for the portions of the examination they actually accomplish, but the supervising physician will sign the report of medical examination in all cases. Physician assistants and nurse practitioners, properly qualified by appropriate training and experience, may complete the PHA.

b. In general, medical examinations and PHAs conducted for the Army will be completed at facilities of the Armed Forces, using military medical officers on Active or Reserve duty, or full-time or part-time civilian employee physicians, with the assistance of dentists, physician assistants, nurse practitioners, optometrists, audiologists, and podiatrists. There may be contract agreements with civilian or Department of Veterans Affairs (DVA) facilities to perform military medical or PHAs or separation examinations for Active or Reserve Component Forces. In such cases, agreements must be worked out with the overseeing Army MTF or Reserve Command to ensure that the medical examinations and/or PHAs are reviewed by individuals who are familiar with the medical retention standards of chapter 3 (for example, military physicians) and can make a competent determination on whether the Soldier meets the medical retention standards of chapter 3 and is therefore medically fit for retention, retirement, or separation and accurately complete a physical profile (DA Form 3349), if necessary.

c. Medical examinations for qualification and admission to the USMA, the U.S. Naval Academy, the U.S. Air Force Academy, and the respective preparatory schools will be conducted in coordination with DODMERB. (See AR 40–29/NAVMEDCOMINST 6120.2/AFR 160–13/CG COMDTINST M6120.8.)

8–8. Hospitalization

Whenever hospitalization is necessary for evaluation in connection with a medical examination or PHA, it may be provided as authorized in AR 40–400.

8–9. Objectives of medical examinations

The objectives of military medical examinations and periodic health assessments are to provide information—

a. To inform the individual of modifiable health risks and to identify potential lifestyle modifications.

b. To initiate treatment of illness.

c. To meet administrative and legal requirements.

d. To update information on current medical conditions, medications, review PULHES, and identify any readiness or deployment limiting conditions.

e. To update the IMR status of the Soldier.

8–10. Recording of medical examinations

a. The results of a medical examination will be recorded on DD Form 2808 and such other forms as may be required. (See AR 40–29/NAVMEDCOMINST 6120.2/AFR 160–13/CG COMDTINST M6120.8 for DODMERB forms.)

b. Results of the PHA will be recorded on the electronic PHA form. If the electronic version is not available, the PHA may be recorded on an SF 600.

c. PHA results will be electronically transferred to DD Form 2766 (Adult Preventive and Chronic Care Flowsheet) automatically.

d. As the electronic health record becomes available, it will be used to record medical examinations and the PHA.

e. Results on the IMR status of the Soldier will be input into MEDPROS.

8–11. Scope of medical examinations

a. The scope of a medical examination is prescribed in paragraph 8–12 and will conform to the intended use of the examination.

b. Limited or screening examinations, special tests, or inspections required for specific purposes (for example, drivers, personnel exposed to industrial hazards, blood donors, food handlers) may be prescribed by other regulations.

c. Each abnormality, whether or not it affects the examinee's medical fitness to perform military duty, will be routinely described. All diagnoses and symptoms will be noted.

8–12. Medical examination requirements and required forms

a. *Required forms.* The required form for all Army military medical examinations (not used for the PHA) is DD Form 2808. The "Laboratory Findings" section of this form may not contain enough space to include all required tests. If additional space is needed, the "Notes" section in box 73 may be used for that purpose. (MTFs are encouraged to use standard overprints, stamps, etc., in box 73 for that purpose.) Table 8–1 contains model entries and explanatory notes for every box on the DD Form 2808. All items are NOT required on all examinations.

b. *All examinations.* The following items ARE REQUIRED on ALL Army military medical examinations, not the PHA, and additional items may be accomplished if clinically indicated. See paragraphs (3) through (8) below for additional items required for special examinations. The box number from the DD Form 2808 that corresponds to the appropriate item to be completed is listed following each item.

(1) *Administrative data*. Date of examination (box 1), SSN (box 2), Name of examinee (box 3), Home address (current address, not "home of record" if different) (box 4), Home or contact telephone number (box 5), Grade/rank (box 6), Date of birth (box 7), Age (box 8), Sex (box 9), Race (box 10), Service (box 15a), Component (box 15b), Purpose of exam (box 15c), and Name of examining facility (box 16). (Name and SSN will also be completed on the top of pages 2 and 3 of the DD Form 2808.)

(2) *Clinical evaluation section (boxes 17 through 39).* This includes examination of head, face, neck, scalp, nose, sinuses, mouth, throat, ears (drums), eyes (includes ophthalmoscopic), heart, lungs, vascular system, anus, abdomen, upper and lower extremities, feet, spine, skin, breast exam, neurologic exam, and testicular exam on males. (Rectal exams are not required on all examinations. Pelvic exams and Pap tests are not required on all female examinations. See paras (3) through (8) below for specific requirements.)

(3) *Dental section (box 43), usually completed by a physician or physician's assistant who will be noting any obvious gross abnormalities.* This does not replace the dental examination by a dentist required in AR 40–3. The physician or physician assistant will check the box acceptable or unacceptable. The section in this item for dental "class" will not be completed unless it is completed by a dentist.

(4) *Notes section (box 44) (to explain any abnormalities).*

(5) *Urinalysis for albumin and sugar (boxes 45a and 45b).*

(6) *Miscellaneous measurements.* Height (box 53), weight (box 54), temperature (box 56), pulse (box 57), blood pressure (box 58*a)*, distant vision (box 61), near vision (box 63), and audiometer results (box 71*a)*.

(7) *Qualification for service (box 74a).* For separation and retirement exams, qualification is based on whether the examinee meets the medical retention standards of chapter 3.

(8) *Physical profile (box 74b).* This section does not replace the requirements for a DA Form 3349 as described in chapter 7.

(9) *Summary of defects (box 77).*

(10) *Recommendations (box 78).*

(11) *Name and signatures of examining physician assistants or nurse practitioner (boxes 81a and 81b), and of examining or approving physician (boxes 82a and 82b or 84a and 84b).*

c. *Separation Health Assessments (See OTSG Policy memos for updates).*

(1) The following four categories of Soldiers are to undergo a separation health assessment (SHA) prior to their separation from AD:

(a) A Soldier who is involuntarily separated from AD.

(b) A Soldier of a reserve component who is separated from AD to which he/she was called or ordered in support of a contingency operation, if the AD was for a period of 31 or more consecutive days (REFRAD).

(c) A Soldier who is separated from AD for which the member was involuntarily retained (Stop-Loss) under Section 12305 of Title 10 USCS in support of a contingency operation.

(d) A Soldier who is separated from AD who served pursuant to a voluntary agreement of the member to remain on AD in support of a contingency operation.

(2) The SHA will consist of—

(a) A current self-reported health status.

(b) A face-to-face interview with a physician, nurse practitioner, or physician assistant to review the Soldier's medical record to identify any complaints or potential AD service-related (incurred or aggravated) illness or injury.

(c) A hands-on physical examination if during interview process it is deemed necessary.

(d) A discussion of the "A" and "B" rated US Preventive Services Task Force recommendations based on the Soldier's age and gender (see table 8–4).

(e) An assessment regarding the Soldier's qualification for retention according to chapter 3.

d. Examination for retirement or all other separations. (In accordance with para 8–24, retirement examinations are mandatory. Separation from the Active Army examinations are conducted on the request of the Soldier or if on review of the medical records it is clinically indicated.) In addition to the items listed in "All Examinations" (*b* (2) above), the following items are required:

(1) Prostate for males age 50 and older (box 30).

(2) Rectal exam with stool for occult blood test for age 50 and older (box 30 for exam). (Use box 73 for occult blood results.)

(3) HCT or HGB (box 47).

(4) PSA test for males 50 and older. (Record results in box 52*b*.)

(5) Urine specific gravity and urine microscopic. (Record results in box 52*c*.)

(6) Chest x–ray (only for Soldiers 40 and older). (Record results in box 73.)

(7) Cholesterol. (Record results in box 73.)

(8) FBS for those 40 and older. (Record in box 73.)

(9) EKG for those 40 and over or if clinically indicated. (Record in box 73.)

(10) See paragraph 8–23*i* for hepatitis screening requirements.

(11) DD Form 2697 (Report of Medical Assessment) will also be completed.

e. Initial examinations for appointment, enlistment, or induction. In addition to the items listed in "All Examinations" (*b* (2) above), the following items are required. (See AR 40–29/NAVMEDCOMINST 6120.2/AFR 160–13/CG COMDTINST M6120.8 for DODMERB exams.)

Note.

MEPCOM will provide instructions to the MEPS on completion of the required forms for Army applicants. These instructions will include additional items on the DD Form 2808 that are to be used solely by the MEPS (for example, boxes 75, 79, and 80).

(1) Pregnancy testing on female applicants (box 46).

(2) HIV testing (box 49). (See AR 600–110.)

(3) Drug and alcohol test. (ROTC cadets will be tested during precommissioning physical (boxes 50 and 51).)

(4) Chest x-ray only if clinically indicated. (Record in box 73.)

(5) Pelvic exams and pap tests are not required, except in the case of an enlisted accession between the ages of 40 to 42 years old; then it is required.

(6) Color vision. (Record results in box 66.)

f. Initial exam for Special Forces, SERE, free fall parachute training (high altitude low opening (HALO), marine diving (Special Forces and Ranger combat diving) and other marine diving (MOS 00B). In addition to the items listed in "All Examinations" (b (2), above), the following items are required:

(1) Rectal exam with stool for occult blood (required for Special Forces, SERE, HALO, Special Forces, and Ranger combat diving) (box 30 for exam). (Use box 73 for occult blood results.)

(2) HCT (box 47).

(3) HIV (box 49).

(4) Urine specific gravity and urine microscopic. (Record in box 52*c*.)

(5) Color vision (boxes 59 and 60).

(6) Refraction, if vision does not correct to 20/20 in each eye with spectacle or contact lenses or if uncorrected vision is worse than 20/70 in either eye (not required for SERE) (box 62).

(7) Valsalva (required for diving and HALO only) (box 72*b)*.

(8) Chest x–ray (frontal view only; not required for SERE). (Record in box 73.)

(9) EKG. (Record in box 73.)

(10) White blood cell count (diving and HALO only). (Record in box 73.)

(11) Sickle cell screen. (Record in box 73.)

(12) Glucose–6–phosphate dehydrogenase (MOS 00B diving, CDQC, and MFF only). (Record in box 73.)

(13) Total Cholesterol, LDL, HDL and Triglycerides (Record in box 73).

(14) The RPR (Record in box 73).

(15) Dental examination by a dentist (not required for SERE).

g. Additional examinations for female Soldiers on active duty or ADT tours in excess of 1 year (see paragraph 8–20*a)*.

h. *Flying duty medical examinations.* (See ATB 2, Army Flight Surgeon's Administrative Guide and chaps 4 and 6 of this regulation).

i. *Airborne examinations.* In addition to the items listed in "All examinations" (*b* (2), above), the following items are required:

(1) Valsalva (box 72*b)*.

(2) Color vision (boxes 59 and 60).

j. *Examination for Ranger School.* In addition to the items listed in "All Examinations" (*b* (2), above) the following items are required:

(1) *Age 34 and under.* Urinalysis with microscopy (box 52), HCT (box 47), HIV test within 2 years (box 49), Sickle Cell (box 73). An evaluation by a dentist is also required.

(2) *Age 35 and older.* Urinalysis with microscopy (box 52), HCT (box 47), HIV test within 2 years (box 49), FBS (box 73), CBC (box 52), Fasting Lipid Panel, EKG, Rectal exam with occult blood. An evaluation by a dentist is also required. The requirements in paragraph 8–25*d* for indications of medical follow-up for elevated or abnormal test results should be followed for these exams on applicants 35 and older and the results forwarded with the medical examination to the Ranger School for review.

8–13. Report of medical history forms

a. *Preparation of DD Form 2807–1.* (DD Form 2807–2 (Medical Prescreen of Medical History Report) is not required.) This form is completed by the examinee prior to being examined. The DD Form 2807–1 must be prepared in all cases when the DD Form 2808 is also completed. It provides the examining physician with an indication of the need for special discussion with the examinee and the areas in which detailed examination, special tests, or consultation referral may be indicated. The information entered on this form is considered confidential and will not be released to unauthorized sources. The examinee should be informed of the confidential nature of his or her entries and comments. Trained enlisted medical service personnel and qualified civilians may be used to instruct and assist examinees in the preparation of the report, but will make no entries on the form other than the date of examination and the examining facility. The DD Form 2807–1 will normally be prepared in an original and one copy. All items will be completed. Responses will be typewritten or printed in ink.

b. *Signature.* The examinee will sign the form in black or dark blue ink.

c. *The physician's (or physician assistant's or nurse practitioner's) summary and elaboration of the examinee's medical history.*

(1) The physician (or physician assistant or nurse practitioner) will summarize and elaborate upon the examinee's medical history, and in the case of military personnel, the examinee's health record, cross–referencing their comments by item number. All items checked in the affirmative will be clarified and the examiner will fully describe all abnormalities including those of a non–disqualifying nature.

(2) If the examinee is applying for enlistment or appointment and answers reveal that he or she was previously rejected for military service or was discharged for medical reasons, the exact reason should be ascertained and recorded.

(3) A facsimile stamp will not be used for signature. The typed or printed name of the physician, physician assistant, or nurse practitioner and the date will be entered in the designated blocks. The physician, physician assistant, or nurse practitioner will sign in black or dark-blue ink.

8–14. Validity times for DD Forms 2808

a. Medical examinations will be valid for the purpose and within the periods prescribed below, provided there has been no significant change in the individual's medical condition. The DD Form 2808 will not be used for the PHA. The physician responsible for the final medical evaluation of the individual being examined will sign and date the report in Block 85. The date recorded in Block 85 on the DD Form 2808 will reflect the date the medical examination is completed.

(1) Medical examinations will be valid for 24 months from the date of medical examination to qualify for entrance into USMA, the USUHS, ROTC, OCS, USMA Preparatory School, induction, enlistment, initial appointment as a commissioned officer or warrant officer (with the exceptions noted in (2), below).

(2) At National Advanced Leaders Camp, a medical screening on DD Form 2807–1, with a focused medical examination if clinically indicated, and laboratory screening tests for DNA, HIV, and drug/alcohol testing will be accomplished. This medical screening and required laboratory tests will be used to qualify a cadet for continuation in ROTC and subsequent commission. The entry examination for USMA may be used as the commission examination providing the DNA, HIV and drug/alcohol tests have been accomplished during the cadet's tenure; and a DD Form 2807–1 is completed prior to commission with a focused medical examination performed if clinically indicated. The entry examination to qualify for Physician Assistant School may be used for the commission examination providing there has been no change in the student's medical condition since the last examination. A DD Form 3081 (Periodic Medical Examination (Statement of Exemption)) will be completed.

(3) See paragraph 6–8 for validity periods for FDMEs.

(4) When accomplished incident to retirement, discharge, or release from active duty, medical examinations or the separation health assessments are valid for a period of 12 months from the date of examination. If the examination or assessment is accomplished more than 6 months prior to discharge, or retirement (or 6 months prior to transition leave date if the Soldier requests it), DD Form 2697 will be attached to the original DD Form 2808 or assessment.

(5) See table 6–1 for FDMEs.

(6) Medical examinations are valid for 60 months from the date of medical examination to qualify for airborne training. If an ROTC or USMA Cadet examination was recorded on DD Form 2351 (DOD Medical Examination Review Board (DODMERB) Report of Medical Examination) instead of DD Form 2808, the examination is still valid. If the examination is older than 2 years, applicants for airborne school must complete DD Form 3081 and note if there has been any known change in their medical condition since the last examination. Any notes that there has been a change needs to be reviewed by a physician to ensure they meet airborne school medical standards.

(7) Medical examinations are valid for 24 months from completion date of medical examination for entrance to all USAJFKSWCS schools. This includes SFAS; Special Forces Qualification Course (SFQC); MFF; Special Forces CDQC; and SERE training. (Military Freefall Jumpmaster, Dive Supervisor, and Diving Medical Technician (DMT) training are not initial qualification courses. As such, these courses only require a current MFF/CDQC physical that is valid for the period specified in 8–19*c* (2.) Candidates for DMT, not on dive status, require an initial CDQC physical to attend this school.)

(8) A current (within the last 12 months) periodic health assessment or medical examination, to include all lab tests and consults, for Active Army Soldiers and ARNGUS and USAR Soldiers will be valid for reenlistment, attendance at Army or civilian schools, ADT, Active Duty Operational Support (ADOS), and temporary tour of active duty tours unless the specific school requires a medical examination or a shorter validity period (for example, special forces, diving school, or aviation training). (See para 8–20*c* for definition of a periodic medical examination for active and RC Soldiers. Shorter validity periods for Army Schools must be prescribed by Army regulation or DA pamphlet.) The periodic examinations or PHA will be valid only if there has been no change in the Soldier's medical condition since the last complete PHA or medical examination. USAR and ARNG/ARNGUS Soldiers will complete DD Form 3081 to indicate there has been no significant change since the last examination. See AR 600–110 for separate requirements for HIV testing.

(9) Medical examinations are valid for 18 months for entry into Ranger School, diving training (MOS OOB), and entry into aviation classes 1/2/3/4.

b. Except for flying duty, discharge, or release from active duty, a medical examination or PHA conducted for one purpose is valid for any other purpose within the prescribed validity periods, provided the examination is of the proper scope specified in table 8–1 or by the prescribing authority. If the examination is deficient in scope, only those tests and procedures needed to meet additional requirements need be accomplished and results recorded.

c. The periodic health assessment or medical examination obtained from members of the ARNG/ARNGUS and USAR as defined in paragraph 8–20*d*(4) will be valid for the purpose of qualifying for immediate reenlistment in ARNG/ARNGUS and USAR, provided there has been no change in the individual's medical condition since their last complete medical examination. (See para 8–19 for requirements at mobilization or contingency operations.)

8–15. Procurement medical examinations

a. For administrative procedures pertaining to procurement medical examinations (para 2–1) conducted at MEPS, see AR 601–270/AFR 33–7/MCO P–1100.75A. For procedures pertaining to appointment and enlistment in the ARNG/ARNGUS and USAR, see chapters 9 and 10 of this regulation. For procedures pertaining to enrollment in the Army ROTC, see AR 145–1. For procedures pertaining to USMA and ROTC Scholarship applicants, see AR 40–29/NAVMEDCOMINST 6120.2/AFR 160–13/CG COMDTINST M6120.8.

b. The procurement medical examination will fulfill the requirement for a PHA for 1 year from the date of the examination (see also para 8–20).

8–16. Active duty for training, active duty for special work, and inactive duty training

a. Individuals on ADT/ADSW for 30 days or less are not required to undergo medical examinations prior to separation unless there is clinical indication for the examination.

b. An individual on ADT/ADSW will be given a medical examination if they incur an injury during such training that may result in disability or he or she alleges medical unfitness or disability.

c. Evaluation of medical fitness will be based on the medical fitness standards contained in chapter 3.

8–17. Retiree Recalls

A current (within the past 12 months) periodic health assessment, separation health assessment, or retirement medical examination is required.

8–18. Health Records

Medical examiners will review the health record (AR 40–66) of each examinee whenever an examination is conducted for the purpose of relief from active duty, resignation, retirement, separation from the Service, or when accomplished in connection with a periodic health assessment. The examiner will note on the DD Form 2766 (Adult Preventive and Chronic Care Flowseet) any significant problems, patient education, and follow–up care, as appropriate.

8–19. Mobilization of units and members of Reserve Components of the Army

A current periodic health assessment or a new medical examination is required incident to mobilization or call-up for war or contingency operations. See paragraph 8–24 for requirements for separation examinations.

8–20. Periodic health assessments

(See para 8–5 for distribution of reports.)

a. *Application.*

(1) An annual periodic health assessment is required for all officers, warrant officers, and enlisted personnel of the Army, regardless of component. All general officers (brigadier general and above) on active duty will undergo a periodic health assessment every 2 years with a physical examination on the alternate years.

(2) Other than required medical surveillance and readiness monitoring, the periodic health assessment is not required for an individual who has undergone a medical examination within 1 year, the scope of which is equal to or greater than that of the required periodic health assessment (such as annual FDME/FDHS).

b. *Procedure.* The periodic health assessment consists of three parts—

(1) Part 1. A self-reported health status. A current self-reported health status and review, to include: A statement of health completed by the Soldier. The electronic version of the PHA, available on AKO is the preferable method of completing the PHA. Other acceptable forms to use for the statement of health, if the electronic version of the PHA is not available, include the DD Form 2795 (Pre-Deployment Health Assessment), the DD Form 2796 (Post-Deployment Health Assessment (PDHA)), DD Form 2900 (Post-Deployment Health Re-Assessment (PDHRA)), or the DD Form 2807–1 (Report of Medical History). The Health Assessment Review Tool (HART–R) will be used for the self-reported health status when it becomes available online. The PHA statement of health will include questions on tobacco use, stress, alcohol abuse, behavioral health and traumatic brain injury exposure as well as questions designed to meet The Joint Commission Accreditation. Whenever possible, the statement of health will be done prior to arrival at the clinic, medical facility, physical exam section, Soldier Readiness Site, or local detachment.

(2) Part 2. A review of the Soldier's height and weight, current medical conditions and deployment related health problems, to include screening for traumatic brain injury exposure, allergies, medications, required immunizations, update of medical readiness laboratory tests, audiology and optometry examination results. The DD Form 2766, Adult Preventive and Chronic Care Flow-sheet will be updated with the most current information. Medical readiness will be documented and/or updated electronically in MEDPROS during the encounter. Screening and patient education (as indicated by AHLTA reminders) will be done and documented to include stress, alcohol and tobacco use/abuse. The Soldier will be

given written recommendations for age and gender appropriate screening laboratory and imaging procedures consistent with the U.S. Preventive Services Task Force (USPSTF) A and B recommendations (http://www.ahrq.gov/clinic/uspstfix.htm and table 8–4) and directed to discuss these recommendations with their primary care manager (PCM).

(3) Parts 1 and 2 of the PHA may be conducted, coordinated and documented by any health care provider to include medics, nursing assistants, licensed practical nurses or registered nurses.

(4) Part 3. A physician, nurse practitioner or physician assistant will—

(a) Review the Soldier's statement of health, completed tests and reports, PULHES, and readiness screening information and make referrals as indicated.

(b) Perform a symptom focused exam to address concerns identified by the Soldier in their self reported health status. The exam will include an assessment for mental health disorders, behavioral health risks to include screening for traumatic brain injury exposure, and physical health conditions that may impact on mental status or emotional well-being. The exam will include an evaluation and treatment of medical problems and women's health services where indicated and authorized.

(c) Whenever possible, the PHA should be accomplished in a single appointment. Refer symptomatic active component Soldiers for evaluation and treatment. *COMPO 1, TRICARE, Prime Remote, COMPO 2 and 3 Soldiers may complete the PHA via the current agencies contracted to provide these medical services.*

(d) The physician, nurse practitioner or physician assistant will assess and document the Soldier's ability to be sustained in an austere environment for at least 30 days. An austere environment is defined as—

1. An area that regularly experiences significant environmental hazards (for example, heat, cold, altitude, aerosole particles) that would exacerbate existing medical conditions when protection (such as climate control) is not available.
2. An area that has limited access to a reliable source of electricity.
3. An area where force protection levels mandate prolonged use of body armor and or chemical protection equipment.

(e) Referrals will be submitted and orders entered for any required preventative or readiness related medical services not immediately available during the PHA process.

(f) The examining physician, nurse practitioner, or physician assistant will thoroughly investigate and document the Soldier's current medical status. The medical findings will be described in detail, using AHLTA if available, or an SF 507 (Medical Record—Report on or Continuation of SF) or SF 600 (Chronological Record of Medical Care).

(g) The PHA status will be reported as complete when the privileged provider reviews and confirms that the PHA has been completed and that all Unit Status Reportable (USR) IMR metrics (current health assessment, routine adult immunizations, HIV, temporary and permanent profiles, deployment-limiting condition(s) and pregnancy status) have been updated in the appropriate electronic systems.

(h) If the Soldier has recently been deployed, the date of completion of DD Form 2900, Post-Deployment Health Reassessment (PDHRA) will also be annotated in MEDPROS. An abbreviated PHA can be completed while completing Form 2796 and Form 2900. The abbreviated PHA is a separate assessment that is accessed while completing DD Form 2796 or DD Form 2900.

(5) Soldiers will be found qualified for retention if they meet the medical retention standards of chapter 3.

(6) Soldiers who do not meet the medical retention standards of chapter 3 will be referred to an MEB. However, for RC and ARNG/ARNGUS Soldiers not on active duty, see chapters 9 and 10.

(7) All periodic health assessments will be reviewed by a physician, nurse practitioner or physician assistant.

(8) The Soldier will be counseled on remedial conditions found upon examination. Referrals will be made for the purpose of instituting care, continuing care for conditions already under treatment, and general health education matters including, but not limited to smoking, alcohol and drug abuse, and weight control.

(9) All personnel with potential hazardous exposures in their work environment for which medical surveillance examinations are required to ensure that there is no harmful effect to their health will receive appropriate medical surveillance examinations. Such examinations will be specific to job exposure.

c. *Followup*. Soldiers of the ARNG/ARNGUS or USAR who are not on active duty will be scheduled for follow-up appointment and consultations at Government expense when authorized. Treatment or correction of conditions or remediable defects as a result of examination will be scheduled if authorized. If individuals are not authorized treatment, they will be advised to consult a private physician of their own choice at their own expense.

d. *Frequency*. (See chap 6 for aviators, ATCs, and FSs.)

(1) All general officers (brigadier general and above) on active duty will undergo a periodic health assessment annually and a physical medical examination every 2 years.

(2) Special Forces/Ranger combat divers and MOS 00B divers must have a physical examination every 5 (five) years. The physical examination for divers must be performed by or reviewed by a DMO or a FS trained in diving medicine. The physical examination for MFF parachutists must be performed or reviewed by a FS every 5 years in conjunction with physiologic training.

(3) All other personnel on active duty will have a periodic health assessment on record no older than 12 months beginning after enlistment or commissioning. Military medical exams conducted for purposes other than the periodic health assessment may be used to comply with the periodic health assessment requirement.

(4) All members of the Selected Reserve not on active duty will have a periodic health assessment at least once every 12 months. Army commanders, the Commander, AHRC, and the Chief, NGB may, at their discretion, direct more frequent medical assessments or physical examinations in individual cases. MEDPROS data will reflect non-compliance if a PHA has not been reported or is older than 15 months.

(5) All members of the Ready Reserves not on active duty will have an annual periodic health assessment. The HART–R (when available) or DA Form 7349 (Initial Medical Review—Annual Medical Certificate) may be used for all Ready Reserve Soldiers to record the results of this periodic health assessment. A medical exam will be accomplished, if, upon review of the form, it is clinically indicated and authorized. The HART–R or DA Form 7349 will be filed in the individual's health record and DD Form 2766. DA Form 3725 (Army Reserve Status and Address Verification) (AR 135–133) is used to meet the annual periodic health assessment for all other Individual Ready Reserve Soldiers.

8–21. Frequency of additional/alternate examinations

a. *Female examinations.*

(1) In addition to the periodic health assessment, all women in the Army, regardless of age, on active duty or ADT/ADSW tours in excess of 1 year or Active Guard—Reserve (AGR) tours will undergo pelvic examinations, to include a cervical cytologic screening test for cancer, annually. Breast examinations will be done in accordance with the USPSTF recommendations (see table 8–4). All women in the Army, under or equal to the age of 25, on active duty or ADT/ADSW tours in excess of 1 year or AGR tours will undergo annual testing for chlamydia. Periodic health assessments for ARNG/ARNGUS and USAR Soldiers not on active duty will include current (within 1 year) pelvic examinations and a cervical cytologic screening test for cancer. Civilian test results attached to the PHA for ARNG/ARNGUS and USAR Soldiers not on active duty will be acceptable.

(2) All women in the Army on active duty (including AGR) or ADT tours in excess of 1 year will have a mammographic study accomplished in accordance with the USPSTF recommendations (see table 8–4). A record of the examination and test results will be maintained in the health record. More frequent mammographic studies may be performed if clinically indicated.

(3) Army applicants are not required to undergo a pelvic examination or a cytologic screening test unless they are between the ages of 40 to 42 years old. However, once enlisted or appointed, the provisions of paragraph 8–21*a*(1) apply.

b. *Medical surveillance examinations.* The frequency of medical surveillance examinations varies according to job exposure. Annual or less frequent examinations will be performed during the birthday month. More frequent examinations will be scheduled during the birthday month and at appropriate intervals thereafter.

8–22. Deferment of examinations

a. *Armywide or at specific installations.* In circumstances requiring Armywide or installation deferment of periodic examinations (where conditions of the Service preclude the accomplishment of periodic examinations or periodic health assessments because resources are being directed to other missions (for example, screening for mobilization/contingency operations, heavy casualties, and so on), requests for exceptions to policies deferring examinations will be forwarded to TSG (ATTN: DASG–HS–AS).

b. *Soldiers in isolated areas.* Periodic health assessments may be delayed by the commander concerned for those Soldiers stationed in isolated areas; that is, Army attaches, military missions, and MAAGs, where medical facilities are not available. Periodic health assessments so delayed will be accomplished at the earliest opportunity in conjunction with leave, temporary duty, or when the individuals concerned are assigned or attached to a military installation having a medical facility. Medical examination of such individuals for retirement purposes may not be delayed.

c. *Other deferments.* In exceptional circumstances, in the case of an individual Soldier, where conditions of the service preclude the accomplishment of the annual periodic health assessment, it may be deferred by direction of the commander having custody of personnel files until such time as its accomplishment becomes feasible. An appropriate entry explaining the deferment will be made in the health record and on an SF 600 when such a situation exists.

8–23. Promotion

Officers, warrant officers, and enlisted personnel, regardless of component, are considered medically qualified for promotion on the basis of the annual periodic health assessment outlined in paragraph 8–20.

8–24. Separation and retirement examinations

a. AC and AGR Personnel (Title 10 or 32) Soldiers separating from the Army will be given a medical interview using DD Form 2697. The interview will be conducted by a physician, physician assistant, or nurse practitioner to document any complaints or potential service–related (incurred or aggravated) illness or injury. The Soldier must acknowledge with his or her signature in block 19 of the form that the information provided is true and complete. This form will be filed in the health record. See paragraph 8–24*i* for hepatitis screening requirements.

(1) Soldiers from AC, USARC and ARNG being considered for administrative separations, including but not limited to chapter 9, Alcohol or other Drug Abuse Rehabilitation Failure; chapter 13, Unsatisfactory Performance; chapter 5-13, Personality Disorder (PD); chapter 5-17, Other Mental Health Condition; and chapter 14-12, Patterns of Misconduct will be screened for both Post Traumatic Stress Disorder (PTSD) and mild Traumatic Brain Injury (mTBI) prior to their discharge. This screening must be in accordance with USAMEDCOM guidance and documented in the progress note located in the Soldier's AHLTA record. A Soldier will not be processed for administrative separation under AR 635–200, paragraph 5–17, if PTSD or mTBI are contributing factors to the diagnosis of PD, but will be evaluated under the physical disability system in accordance with AR 635–40.

(2) DODI 1332.14, and OTSG Policy Memo, prescribes the following requirements on separations based on Personality Disorder for enlisted Soldiers who have served or are currently serving in imminent danger pay areas—

(a) a psychiatrist or PhD-level psychologist must diagnose the PD;

(b) the diagnosis must be corroborated by MTF chief of behavioral health (or an equivalent official);

(c) the corroborated diagnosis, with all supporting medical documentation, will be forwarded for final review and endorsement by the Director, Proponency of Behavioral Health, Office of The Surgeon General (DASG–HSZ), 5109 Leesburg Pike, Suite 693, Falls Church, VA 22041–3258; and

(d) the diagnosis must address post traumatic stress disorder (PTSD) or other co-morbid mental illness, if present.

(3) 10 USC 1177 requires a medical examination in certain instances prior to administrative separation of Soldiers under conditions other than honorable. Separation authorities will ensure medical examinations are completed for any Soldier, officer or enlisted, pending administrative separation under conditions other than honorable who has been deployed overseas in support of a contingency operation or sexually assaulted during the previous 24 months, and who is diagnosed with PTSD and/or traumatic brain injury (TBI), or who otherwise reasonably alleges the influence of such condition based on their service while deployed or based on such sexual assault.

(a) The purpose of the medical examination is to assess whether the effects of PTSD and/or TBI constitute matters in extenuation that relate to the basis for administrative separation under other than honorable conditions or the overall characterization of service of the member as other than honorable.

(b) In cases involving PTSD, the medical examination may be performed by a clinical psychologist, psychiatrist, licensed clinical social worker, or psychiatric advanced practice registered nurse.

(c) In cases involving TBI, the medical examination may be performed by a physician, clinical psychologist, psychiatrist, or other health care professional, as appropriate.

(d) The examination may be in accordance with USAMEDCOM guidance and documented in the Soldier's electronic health record. The appropriate DA form, currently the DA 3822, will be generated and remain accessible via the electronic health record.

(e) The requirements of this subparagraph apply to every administrative separation meeting the criteria in paragraph 8–24*a*(3) above, regardless of whether separation is involuntary or at the Soldier's request. This includes cases involving enlisted Soldiers who request administrative separation under AR 635–200, in lieu of trial by court-martial, and officers who request resignation in lieu of trial by court-martial under AR 600–8–24. The medical examination and procedures required by 10 USC 1177 do not apply to courts-martial or other proceedings conducted pursuant to the Uniform Code of Military Justice.

(f) For purposes of paragraph 8–24*a*(3) only, "sexually assaulted" means that the Soldier facing separation has made a report of sexual assault punishable under Article 120, Uniform Code of Military Justice. No finding of probable cause by an investigation is required.

b. Soldiers separating from the Army will receive a separation medical examination if the Soldier requests it, or if, on review of the medical records or the DD Form 2697, a physician, a physician assistant, or a nurse practitioner feels an examination is appropriate (with exception noted in *c*, below). See table 8–2 for additional requirements based on the type of discharge. See *d*, below, for Soldiers retiring from active service.

c. Separation Health Assessments (See OTSG policy memos for updates).

(1) The following four categories of Soldiers are to undergo a separation health assessment (SHA) prior to their separation from AD:

(a) A Soldier who is involuntarily separated from AD. A Soldier who is involuntarily separated from AD. The Soldier must be available to complete the SHA. For incarcerated Soldiers in civilian prisons, the initial prison physical examination done by a credentialed provider meets the intent of an SHA.

(b) A Soldier of a reserve component who is separated from AD to which he/she was called or ordered in support of a contingency operation, if the AD was for a period of 31 or more consecutive days (REFRAD).

(c) A Soldier who is separated from AD for which the member was involuntarily retained (Stop-Loss) under Section 12305, Title 10 USC in support of a contingency operation.

(d) A Soldier who is separated from AD who served pursuant to a voluntary agreement of the member to remain on AD in support of a contingency operation.

(e) ARNG/ARNGUS or USAR Soldiers ordered to active duty for war, national emergency, or Presidential Select Reserve Call-Up (10 USC 12301(a), 12302, 12304, or 12305) will undergo a separation health assessment prior to mustering out of Federal service (ARNG/ARNGUS) or release from active duty (USAR). The scope of this screening (for example, medical interview with an individualized focused examination if clinically indicated vs. a complete medical examination) maybe changed by TSG prior to separation based on length of the mobilization/contingency operation and occupational exposures of the Soldiers. However, all Soldiers, as a minimum, will complete DD Form 2796 prior to mustering out of Federal service or release from active duty in accordance with a, above.

(2) The SHA is an individualized health assessment sufficient to evaluate the health of the Soldier at the time of discharge and will consist of—

(a) A current self-reported health status.

(b) A face-to-face interview with a physician, nurse practitioner, or physician assistant to review the Soldier's medical record to identify any complaints or potential AD service-related (incurred or aggravated) illness or injury.

(c) A hands-on physical examination if during interview process it is deemed necessary.

(d) A discussion of the "A" and "B" rated U.S. Preventive Services Task Force recommendations based on the Soldier's age and gender (see table 8–4).

(e) An assessment regarding the Soldier's qualification for retention according to chapter 3.

(3) The SHA may only be waived if the Soldier has undergone a physical examination or assessment within 12 months prior to separation or discharge, and then only with the consent of the Soldier and concurrence of their unit commander.

d. Soldiers retiring from active duty to include AGR personnel (Title 10 or 32) are required to undergo a medical examination prior to retirement. The retirement medical examination may be a combined DOD/VA physical examination or a VA physical examination for the pilot programs, as long as the physician documents any complaints or potential service-related (incurred or aggravated) illness or injury and determines if the Soldier meets the medical retention standards of chapter 3.

e. Soldiers in paragraphs *a*, *b*, and *d*, above, who have indicated on DD Form 2697 that they intend to seek VA disability compensation or who have been referred to the Army Disability Evaluation System for determination of fitness will be given a standard VA compensation and pension physical, in conjunction with the combined DOD/DVA physical examination. For those Soldiers, the service medical record, proof of line of duty (LOD) determination, if necessary, and recent laboratory, radiological, and all other associated test results should accompany the claimant for VA benefits to the place of examination so that testing is not duplicated. A complete review of systems that documents the individual's physical condition at the time of retirement from the military service shall also be conducted as part of the physical examination to minimize duplication.

f. Voluntary requests for medical examinations should be submitted to the commander of the servicing MTF not earlier than 6 months nor later than 1 month prior to the anticipated date of separation or retirement (or if applicable and requested by the Soldier, 6 months prior to transition leave). If the examination is accomplished earlier than 6 months, *g*, below, applies.

g. When accomplished incident to retirement, discharge, or release from active duty, medical examinations, annual periodic health assessments, or separation health assessments are valid for a period of 12 months from the date of examination/assessment.

h. Soldiers who have been in medical surveillance programs because of hazardous job exposure will have a clinical evaluation and specific laboratory tests accomplished prior to separation even though a complete medical examination may not be required.

i. Soldiers requesting HCV screening will be tested. If the test is positive, medical evaluation to confirm HCV infection, to determine the need for specific treatments, and to provide counseling on lifestyle modifications and steps to protect others from infection will be accomplished. The following statements will overprinted on a DA Form 4700 (Medical Record—Supplemental Medical Data), administered and placed in the medical record for all Soldiers separating or retiring from active duty:

(1) Hepatitis C virus (HCV) is transmitted primarily by injections (for example, blood transfusions, contaminated needles, or sticks with contaminated sharp objects) of contaminated blood. The following are possible sources of HCV infection. If you can answer "yes" to any of these risk factors, you should receive a sample blood test to determine if you could have HCV. If you consider yourself at risk, based on an exposure to a possible source of HCV, you should have a simple blood test for HCV. You will not be asked to identify any specific risk factors to justify HCV testing. If the test is positive, you will receive a medical evaluation to confirm HCV infection, determine your need for specific treatments, and be provided counseling on lifestyle modifications and steps to protect others from infection.

(2) Risk factors are—

(a) Receiving a transfusion of blood or blood products before 1992.

(b) Ever injecting illegal drugs, including use once many years ago.

(c) Receiving clotting factor concentrates produced before 1987.

(d) Having chronic (long term) hemodialysis.

(e) Being told that you have persistent abnormal liver enzyme tests (alanine aminotransferase) or an unexplained liver disease.

(f) Receiving an organ transplant before July 1992.

(g) Having a needle stick, sharps, or mucosal exposure to potentially HCV-infected blood as part of your occupational duties and not having been previously evaluated for HCV infection.

(3) If the test is positive, you will receive a medical evaluation to confirm HCV infection, determine your need for specific treatments, and be provided counseling on lifestyle modifications and steps to protect others from infection.

(4) Circle yes or no to the following responses and sign and date.

(a) No—I do not want to be tested for HCV.

(b) Yes—I want to be tested for HCV.

(c) Signature and date.

8–25. Miscellaneous medical examinations

a. The SFAS, SFQC, MFF parachutists, Special Forces/Ranger Combat divers, and SERE medical examination reports.

(1) Entrance into SFAS, SFQC, MFF parachuting, Special Forces/Ranger Combat diving, and SERE training will only be accomplished after meeting the medical fitness standards documented by the completion of the appropriate physical exam. The completed DD Form 2808 and DD Form 2807–1 (and supporting documents) must be reviewed and stamped "approved" by the U.S. Army Special Operations Command (USASOC) Surgeon's Office, or the surgeon's office that is designated by the USASOC Surgeon's Office as having review and approval authority.

(2) The Commander, USAJFKSWCS is the waiver authority for USAJFKSWCS schools. Individuals not meeting the medical fitness standards for USAJFKSWCS training courses will have their physicals and requests for waiver forwarded to Commander, USAJFKSWCS, ATTN: AOJK–GRP–C, Fort Bragg, NC, 28307–5217.

b. Certain geographic areas.

(1) When an individual is alerted for movement to or is placed on orders for assignment to the system of Army attaches, military missions, MAAGs, or to isolated areas, the commander of the station to which he or she is assigned will refer the individual and his or her dependents, if any, to the medical facility of the command.

(2) The physician of the facility will carefully review the health records and other available medical records of these individuals. Medical fitness standards and factors to consider in the evaluation are contained in paragraph 5–14. Review of the medical records will be supplemented by personal interviews with the individuals to obtain pertinent information concerning their state of health. The physician will consider such other factors as length of time since the last periodic health assessment or medical examination, age, and the physical adaptability of the individual to the new area.

(3) If, after review of records and discussion, it appears that a complete medical examination is indicated, a medical examination will be accomplished.

(4) The commander having processing responsibility will ensure that this medical action is completed prior to the individual's departure from his or her home station.

(5) If, as a result of their review of available medical records, discussion with the individual, and findings of the medical examination, the physician finds the individual medically qualified in every respect under paragraph 5–14*c* and qualified to meet the conditions that will be encountered in the area of contemplated assignment, he or she will complete and sign DA Form 3083 (Medical Examination for Certain Geographical Areas) prior to a permanent change of station. A copy of this statement will be filed in the health record or outpatient record (AR 40–66) and a copy forwarded to the commander who referred the individual to the medical facility.

(6) All family members will be screened following procedures in AR 608–75, Exceptional Family Member Program (EFMP). If any family member meets the criteria for enrollment in EFMP, the assignment will be coordinated with medical and educational representatives, as appropriate, to determine the availability of identified required services. If the medical

needs cannot be met in the projected assignment area, the medical representative will recommend disapproval of accompanied family travel. The examiner will not disclose the cause of the disqualification of a dependent to the commander without the consent of the dependent, if an adult or a parent if the disqualification relates to a minor. If the Soldier or dependent is considered disqualified temporarily, the commander will be so informed and a reexamination scheduled following resolution of the condition.

(7) If the disqualification of the Soldier is permanent or if it is determined that the disqualifying condition will be present for an extended period of time, the physician may refer the Soldier to an MEB if the Soldier does not meet medical retention standards. The DA Form 3349 will be completed outlining specific limitations.

8–26. Cardiovascular Screening Program (CVSP)

a. The CVSP is required as part of the periodic health assessment for all the Active Army, ARNG/ARNGUS, and USAR (Selective Reserve) Soldiers age 40 and older. Cardiovascular screening will be done every five years unless otherwise clinically indicated. The CVSP begins with a Level 1 evaluation.

b. The Level I cardiovascular evaluation is conducted to determine the cardiovascular risk based on the presence of independent risk factors identified. The Level I evaluation will consist of:—

(1) Medical history to include family and smoking history.
(2) Medical records review.
(3) Blood pressure.
(4) Fasting lipid profile, including total cholesterol, LDL, HDL, and triglycerides.
(5) Electrocardiogram (ECG).
(6) Fasting blood glucose.
(7) Height and weight.
(8) Calculation of a Framingham 10-year risk percentage. The National Cholesterol Education Program offers an online tool for calculating the Framingham 10-year coronary heart disease (CHD) risks. The site is: http://hin.nhlbi.nih.gov/atpiii/calculator.asp?usertype=prof and a downloadable version is at http://hin.nhlbi.nih.gov/atpii/riskcalc.htm. MEDPROS Framingham Tool (when available) may also be used.

c. Those Soldiers with the following findings on the ECG will require a Level II screening independent of the Framingham risk score:

(1) Any supraventricular tachycardia (3 or more beats at a rate greater than 100) to include atrial fibrillation/flutter, multifocal atrial tachycardia, junctional tachycardia, and persistent sinus tachycardia.
(2) Conduction disturbances of left bundle branch block (QRS duration more than 120 msec), Mobitz type II second degree atrioventricular (AV) block, and third degree AV block.
(3) Short PR interval (PR interval less than 120 milliseconds (msec) in all 12 leads).
(4) Sinus pause or asystole greater than 2 seconds in duration.

d. For those Soldiers with Framingham 10-year risk scores of between 10 percent and 15 percent, they will be referred to their primary care provider (PCM) for cardiac risk reduction treatment and education. The purpose of the medical referral is to confirm the presence of modifiable coronary risk factors and to advise and initiate medically appropriate treatments with the intent to modify cardiovascular risk. PCMs may further characterize risk by measuring C-Reactive Protein (CRP) and assessing for metabolic syndrome. If CRP is elevated or metabolic syndrome is present, the PCM should consider referring these Soldiers for Level II evaluation and reevaluating them annually.

(1) Primary care providers should use the National Cholesterol Education Program (NCEP) Adult Treatment Panel III (ATP III) or later version, the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure, and other appropriate clinical practice guidelines.
(2) If the Soldier is already under treatment and the Framingham 10-year risk score is less than 10 percent while on treatment, a separate referral for the purpose of the CVSP is not required. The medical records need to document the medical history, what treatment the Soldier is currently on, and where the Soldier is obtaining the treatment. If the risk score is between 10 percent and 15 percent, the Soldier will be referred back to his or her PCM for further care.
(3) Soldiers with hypertension should have a treatment plan for controlling his/her blood pressure documented by a PCM.

e. Except where otherwise eligible for military healthcare—

(1) Reserve Component Soldiers will be referred to their own medical provider for any further followup evaluation and treatment. The Soldier will provide copies of any records (pertaining to their medical management) from their civilian medical provider for inclusion in their military medical health record.
(2) If modification of risk factors improves the Framingham score sufficiently, the ARNG may clear the Soldier on the recalculated index and will not require any further screening or evaluation.

(3) If the modification of risk factors has not sufficiently improved the Soldier's Framingham score, or as required for clearance to participate in the APFT, the ARNG command surgeons or their clinical designees may authorize the specific cardiovascular screening tests as directed in AR 40–501, utilizing ARNG funds, to determine the CV status of the Soldier and/or deployment status.

f. For those Soldiers with a Framingham ten-year risk score of greater than 15 percent, a history of coronary heart disease (CHD) or a CHD-risk equivalent (peripheral arterial disease, abdominal aortic aneurysm, symptomatic carotid artery disease and diabetes), they must undergo a Level II evaluation. The Level II evaluation will consist of non-invasive testing using one (or more, when medically indicated) of the following tests:

(1) The Graded Exercise Stress Test (GXT; Bruce or modified Bruce protocols). If, during the GXT, blood pressure increases to greater than 200 mmHg systolic or 100 mmHg diastolic during or after exercise, an echocardiogram is recommended to rule out pathologic ventricular hypertrophy.

(2) Myocardial perfusion scintigraphy (thallium, sestamibi).

(3) Exercise and/or pharmacologic stress echocardiography.

(4) Once a Soldier has been cleared based on a Level II evaluation, reevaluation will be specified by the consulted cardiologist (or primary care doctor with the credentials to perform/interpret the Level II test). Typically, such Soldiers need reevaluation in 3 years; and sooner if they develop new symptoms or an increase in cardiac risk factors.

(5) Soldiers with metabolic syndrome (three or more of the following: waist greater than 40 inches for males and greater than 35 inches for females; triglycerides greater than 150 mcg/dl; blood pressure greater than 130/85 mm Hg; HDL less than 40 mg/dl; fasting blood glucose greater than or equal to 110 mg/dl) are at increased risk for coronary artery disease and should be reevaluated at least annually. These Soldiers must be treated aggressively using a multimodal approach including pharmacologic therapy, weight reduction, diet counseling, exercise and control of other risk factors.

(6) Soldiers who fail a Level II evaluation should receive a DA Form 3349 restricting them from strenuous activities until the Soldier is tested further and cleared for duty.

g. Medical records will be annotated that any required referrals have been made. All evaluations and recommendations from the medical followup examination on active and RC Soldiers will be placed in the medical record.

h. For all Soldiers upon reaching the age of 40, there is no need to require the cardiovascular screen prior to continuing PT and participating in the APFT. However, if a physician feels a profile restricting physical activity is warranted, they will complete the medical profile DA Form 3349 in accordance with chapter 7.

8–27. Speech Recognition in Noise Test for H3 profile Soldiers

a. The Speech Recognition in Noise Test (SPRINT) will be used by audiologists at all Army facilities to assess all H–3 Soldiers to provide recommendations concerning a potential communication handicap. The SPRINT will be administered by audiologists in a sound treated room, under earphones without use of hearing aids.

b. The tape-recorded test consists of monosyllabic words from the NU–6 lists in a background of speech babble noise. Normative data has been developed (see fig 8–1) so that the Soldier's score can be compared to a large sample of H–3 Soldiers' scores. This score, as a function of the Soldier's length in service, will be used to determine an appropriate recommendation based on table 8–3.

c. These recommendations should be made to MMRBs and MEBs, and considered when completing the physical profile assignment limitations on DA Form 3349. The recommendations provide appropriate information with which the boards can make a final determination.

Table 8–1
Recording of medical examination

Item box number		Explanatory notes and model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
1	(Date of examination)	Enter the date on which the medical examination is accomplished.
2	(Social Security number)	Examinee's Social Security number. (SSN 396–38–0699)
3	(Name)	The entire last name, first name, and middle name are recorded. When Jr. or similar designation is used, it will appear after the middle name. (Jackson, Charles John)
4	(Home address)	Examinee's current mailing address (not the "home of record" —if different) (Street number, City, State, Zip Code or Unit mailing address).
5	(Telephone number)	Enter telephone number where the examinee can be reached—home or unit (202–555–1212).
6	(Grade)	Enter examinee's grade (E8, O4).
7	(Date of birth)	Record as year, month, day.
8	(Age)	List years of age at the time of examination (28 yr.)
9	(Sex)	Check female or male.
10	(Race)	Check the applicable block.

Table 8–1
Recording of medical examination—Continued

Item box number		Explanatory notes and model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
11	(Years of government service)	Not required.
12	(Agency if not DOD)	To be used by other agencies, as appropriate.
13	(Organization unit)	The examinee's current military unit of assignment, Active or Reserve. If no current military affiliation, enter a dash. (for example, "B Company, 2D Battalion, 325th, Infantry, 82nd Airborne Division, Fort Bragg, NC 28307–5100")
14a	(Rating or specialty) (Aviators only)	Not required on Army examinations unless directed by USAAMA.
14b	Total Flying Time (Aviators only)	Not required on Army examinations unless directed by USAAMA.
14c	Last 6 Months (Flying Time – Aviators only)	Not required on Army examinations unless directed by USAAMA.
15a	(Service)	Check the appropriate service.
15b	(Component)	Check the appropriate component.
15c	(Purpose of examination)	Check or enter the purpose of the examination.
16	(Name of examining facility)	Name of the examining facility or examiner and address. If an Army post office, include local national location (Military Entrance Processing Station, 310 Gaston Ave., Fairmont, WV 12441–3217).
17[2]	(Head, face, neck, scalp)	Record all swollen glands, deformities, or imperfections of the head or face. If a defect of the head or face, such as moderate or severe acne, cyst, exostosis, or scarring of the face is detected, a statement will be made as to whether this defect will interfere with the wearing of military clothing or equipment. If enlarged lymph nodes of the neck are detected they will be described in detail and a clinical opinion of the etiology will be recorded.
18	(Nose)	Record all abnormal findings. Record estimated percent of obstruction to airflow if septal deviation, enlarged turbinates, or spurs are present.
19	(Sinuses)	Record all abnormal findings ("Marked tenderness over left maxillary sinus").
20	(Mouth, throat)	Record any abnormal findings. Enucleated tonsils are considered abnormal. (Tonsils enucleated)
21	(Ears)	If operative scars are noted over the mastoid area, a notation of simple or radical mastoidectomy will be entered (for example, "Bilateral severe swelling, injection and tenderness of both ear canals").
22	(Eardrums)	Record all abnormal findings. In the event of scarring of the tympanic membrane, the percent of involvement of the membrane will be recorded as well as the mobility of the membrane. If tested, a definite statement will be made as to whether the eardrums move on valsalva maneuver or not and also noted in item 72b.
23	(Eyes)	Record abnormal findings. If ptosis of lids is detected, a statement will be made as to the cause and extent of the interference with vision. When pterygium is found, the following should be noted: 1. Encroachment on the cornea, in millimeters, 2. Progression, 3. Vascularity.
24	(Ophthalmoscope)	For example, "Ptosis, bilateral, congenital. Does not interfere with vision. Pterygium, left eye, 3mm encroachment on cornea; nonprogressive, avascular." Whenever opacities of the lens are detected, a statement is required regarding size, progression since last examination, and interference with vision (for example, "Redistribution of pigment, macular, Rt eye, no loss of visual function. No evidence of active organic disease").
25	(Pupils)	Record all abnormal findings.
26	(Ocular motility)	Record all abnormal findings.
27	(Heart)	Abnormal heart findings are to be described completely. Whenever a cardiac murmur is heard, the time in the cardiac cycle, the intensity, the location, transmission, effect of respiration, or change in the position, and a statement as to whether the murmur is organic or functional will be included. When murmurs are described by grade, indicate basis of grade (for example, "Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted. Disappears on exercise and deep inspirations, physiological murmur").
28	(Lungs and chest)	Lungs: If rales are detected, state cause. The examinee will be evaluated on the basis of the cause of the pulmonary rales or other abnormal sounds and not simply on the presence of such sounds (for example, "Sibilant and sonorous rales throughout chest. Prolonged expiration").

Table 8–1
Recording of medical examination—Continued

Item box number		Explanatory notes and model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
29	(Vascular system)	Breast exam: Note location, size, shape, consistency, discreteness, mobility, tenderness, erythema, dimpling over the mass, etc. Adequately describe any abnormalities. When varicose veins are present, a statement will include location, severity, and evidence of venous insufficiency (for example, "Varicose veins, mild, posterior superficial veins of legs. No evidence of venous insufficiency").
30	(Anus, rectum) (Prostate if indicated)	A definite statement will be made that exam has been performed. Note surgical scars and hemorrhoids in regard to size, number, severity, and location. Check fistula, cysts, and other abnormalities (for example, "One small external hemorrhoid, mild. Digital rectal normal. Stool guaiac negative"). In prostate exam note grade of prostatic enlargement, surface, consistency, shape, size, sensitivity, mobility.
31	(Abdomen, viscera)	Include hernia. Note any abdominal scars and describe the length in inches, location, and direction. If a dilated inguinal ring is found, a statement will be included in item 31 as to the presence or absence of a hernia (2-inch linear diagonal scar, right lower quadrant).
32	(External genitalia)	Describe any abnormalities. **Include results of testicular exam on males.**
33	(Upper extremities)	Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the upper extremity, as, for example, a history of a broken arm with no significant finding at the time of examination, indicate that no deformity exists and function is normal. A positive statement is to be made even though the "normal" column is checked. If a history of dislocation is obtained, a statement that function is normal at this examination, if appropriate, is desired (for example, "No weakness, deformity, or limitation of motion, left arm").
34	(Lower extremities)	Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the lower extremity, as, for example, a history of a broken leg with no significant finding at the time of examination, indicate that no deformity exists and function is normal. A positive statement is to be made even though the "normal" column is checked. If a history of dislocation is obtained, a statement that function is normal at this examination, if appropriate, is required (for example, "No weakness, deformity, or limitation of motion, left leg").
35	(Feet)	Record any abnormality. When flat feet are detected a statement will be made as to the stability of the foot, presence of symptoms, presence of eversion, stable, bulging of the inner border, and rotation of the astragalus. Pes planus will not be expressed in degree but should be recorded as mild, moderate, or severe (for example, "Flat feet, moderate. Foot asymptomatic, no eversion or bulging; no rotation"). Circle category relating to arch, degree, and symptoms.
36	(Spine, other musculoskeletal)	Include pelvis, sacroiliac, and lumbosacral joints. Check history. If scoliosis is detected, the amount and location of deviation in inches from the midline will be stated.
37	(Identifying body marks)	Only scars or marks of purely identifying significance or those that interfere with function are recorded here. Tattoos that are obscene or so extensive as to be unsightly will be described fully (for example, "1-in. vertical scar, dorsum; 3-in. heart–left forearm; shaped tattoo, lateral aspect middle 1/3 left arm").
38	(Skin)	Describe pilonidal cyst or sinus. If skin disease is present, its chronicity and response to treatment should be recorded. State also whether the skin disease will interfere with the wearing of military clothing or equipment (for example, "Small discrete angular, flat papules of flexor surface of forearms with scant scale; violaceous in color; umbilicated appearance and tendency to linear grouping").
39	(Neurologic)	Record complete description of any abnormality.
40	(Psychiatric)	Record all abnormalities. Before a psychiatric diagnosis is made, a minimum psychiatric evaluation will include Axis I, II, and III.
41	(Pelvic)	Note type of exam (for example, "bi-manual"). Record any abnormal findings. (See item 52a for pap smear.)
42	(Endocrine)	Describe every abnormality noted.
43	(Dental)	Examining physicians will apply the appropriate standards prescribed by chapters 2, 3, 4, or 6, and indicate "acceptable" or "non-acceptable." This does not replace the required annual dental examination by a dentist or the dentist's determination of the appropriate dental classification.

Table 8–1
Recording of medical examination—Continued

Item box number		Explanatory notes and model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
44	(Notes)	Describe every abnormality noted. Enter pertinent item number before each comment. Continue in item 73 if necessary.
45[3]	(Urinalysis) a. Albumin b. Sugar	Record results (For other urine microscopic or specific gravity, record in box 52c.)
46	(Urine HcG)	Record results
47	(Hemoglobin/hematocrit)	Record Results
48	Blood Type	Record Results
49	(HIV)	Record date, results, add HIV specimen ID label in indicated section.
50	(Drugs)	Record results of Drug Tests, add Drug Test Specimen ID to indicated space.
51	(Alcohol)	Record results of alcohol screen
52	(Other / results)	52a (use to record results of pap smear) 52b (use to record PSA result) 52c (use to record urine microscopic or urine specific gravity.)
53	(Height)	Record in inches to the nearest quarter inch (without shoes). For initial Class 1 and initial Class 2 (Aviator), and continuance Class 2 (Aviator) not previously measured: Leg length, sitting height, and functional arm reach will be measured, in accordance with Aeromedical policy letters.
54	(Weight)	Record in pounds to the nearest whole pound (in PT clothes without shoes, or hospital gown).
55	(Maximal allowable weight)	This item is for accession medical examinations only. This does not replace the official weigh-in for Soldiers in conjunction with the APFT and AR 600–9
56	(Temperature)	Record in degrees Fahrenheit to the nearest tenth
57	(Pulse)	Record with arm at heart level
58 a,b,c	(Blood pressure)	Record Results (for example, 110/76) 58 b and c are only required if elevated.
59	(Red/green vision test)	If examinee fails the color vision test in item 66, he/she will be tested to ensure he/she can distinguish between vivid red and vivid green and the results recorded as pass or fail.
60	(Other eye or vision test)	For example, results of red lens test.
61	(Distant vision)	Record in terms of the English Snellen Linear System (20/20, 20/30, etc.) of the uncorrected vision of each eye. If uncorrected vision of either eye is less than 20/20, entry will be made of the corrected vision of each eye (for example, “Right 20/50 corrected (corr) to 20/20 and Left 20/70 corr to 20/20”).
62	(Refraction)	The word “manifest” or “cycloplegic,” whichever is acceptable, will be entered after refraction. An emmetropic eye will be indicated by plano or 0. For corrective lens, record refractive value (for example, “Right By –1.25 S – 0.25 CX 005. Left By – 1.75 S – 0.25 CX 175”).
63	(Near vision)	Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20), enter the corrected vision for each eye and lens value after the word “by” (for example, “Right 20/40 corr to 20/20 by Same and Left 20/40 corr to 20/20 by + 0.50”).
64	(Heterophoria)	Identify the test used; for example, either Maddox Rod or Stereoscope, Vision Testing (SVT), and record results, Prism Divergence not required. All subjective tests will be at 20 feet or at a distance setting of the SVT. Record distance interpupillary distance (PD) in mm (for example, “Esophoria degree 4 Exophoria degree 0. right hyperphoria 0 left hyperphoria 0., PD 63”).
65	(Accommodation)	Record values without using the word “diopters” or symbols (for example, “Right 10.0; Left 9.5”).
66	(Color vision)	Record results in terms of test used, the results and the number of plates missed over number of plates in test. The FALANT (USN) may be utilized. If the examinee fails either of these tests, he or she will be tested for Red/Green vision and the results recorded in item 59 (for example, “PIP, pass, 3/14 or PIP, fail, 9/14”).
67	(Depth perception)	Identify the test used. Record the results “Corrected” or “Uncorrected,” as applicable. Enter the score for Verhoeff or vision testing apparatus as “pass” or “fail” plus the number missed over maximum score for that test (for example, “Verhoeff pass 0/8; vision test apparatus (VTA) pass through D; VTA fail 1/9. Randot circles pass 0/10”).

Table 8–1
Recording of medical examination—Continued

Item box number		Explanatory notes and model entries (Model entries are in parentheses) Refer to the glossary for acronyms and abbreviations used
68	(Field of vision)	Identify the test used and the results. If a vision field defect is found or suspected in the confrontation test, a more exact perimetric test is made using a perimeter and/or tangent screen. Findings are recorded on a visual chart and described in item 77. Copy of the visual chart must accompany the original DD Form 2808 (for example, "Confrontation test: Normal, full").
69	(Night vision)	Test used and Score
70	(Intraocular tension)	Identify type of test used: applanation or non-contact. Record results numerically in millimeters of mercury of intraocular pressure. Describe any abnormalities (for example, "Normal O.D. 18.9 O.S. 17.3").
71a,b	(Audiometer)	Test and record results at 500, 1000, 2000, 3000, 4000, and 6000 Hertz using procedures prescribed in DA Pam 40–501. (71b is used for repeat tests if applicable)
72a	(Read Aloud Test)	Enter RAT satisfactory or unsatisfactory
72b	(Valsalva)	Enter satisfactory or unsatisfactory
73	(Notes)	Examiner will enter notes on examination as necessary. Significant medical events in the individual's life, such as major illnesses or injuries and any illness or injury since the last in-service medical examination, will also be entered. Such information will be developed by reviewing health record entries and questioning the examinee. Complications or sequelae, or absence thereof, will be noted where appropriate. Comments from other items may also be continued in this space. This space is also used for additional tests when there is no specific box for the test on the DD Form 2808. For instance enter the results, if accomplished, of EKGs, chest x–rays, FBS, Fasting lipid profile, cholesterol, occult blood tests, sickle cell screens. Overprints or stamps may be used in this space.
74a[4]	(Examinee/applicant qualification)	Indicate is qualified or not qualified for service. **NOTE: EXAMINER SHOULD CORRESPOND THIS WITH THE PURPOSE OF THE EXAMINATION AS CHECKED IN ITEM 15c AND MUST CHECK EITHER QUALIFIED OR UNQUALIFIED IN THIS SECTION AND INSERT WHAT THE Soldier/APPLICANT IS QUALIFIED FOR (FOR EXAMPLE, "QUALIFIED FOR ACCESSION (Chap 2); QUALIFIED FOR RETENTION (Chap 3); QUALIFIED FOR SEPARATION (Chap 3); QUALIFIED FOR RETIREMENT (Chap 3)").**
74b	(Physical profile)	The physical profile as prescribed in chapter 7 will be recorded. Any permanent profile with above a numerical designator of 1 should have a DA Form 3349 attached (for example, "111121").
75	(Signature of examinee)	The examinee will sign the DD Form 2808 if he/she has a disqualifying condition to indicate that he/she has been advised of the disqualifying condition.
76	(Significant or Disqualifying Defects)	List the significant or disqualifying defects. On accession exams, list the correct ICD 9 code from chapter 2 that corresponds to the disqualifying condition. Any medical waivers for accession should also be noted here.
77	(Summary of defects)	Summarize medical and dental defects considered to be significant. Those defects considered serious enough to require disqualification or future consideration, such as waiver or more complete survey, must be recorded. Also record any defect that may be of future significance, such as nonstatic defects that may become worse. Enter item number followed by a short, concise diagnosis; do not repeat the full description of a defect that has already been described under the appropriate item. Do not summarize minor, non-significant findings.
78	(Recommendations)	Notation will be made of any further specialized examinations or tests that are indicated.
79	(MEPS WORKLOAD)	(MEPS use only)
80	(Medical inspection date and physicians signature)	Used at the MEPS and includes inspection prior to movement to basic training of ht, wt, body fat if applicable, pregnancy test and a note of qualified or unqualified. The physician signature is the physician who has done the inspection and should not be confused with items 83–85 that are the signatures of the medical examiners who accomplished and reviewed the medical examination.
81–84	(Physician or examiner)	Enter the typed or printed names of examiner and signature (physician, physician assistant (PA), or NP). If examination is not performed by a physician, a physician must co-sign the form in item 82a.
85	Administrative review	Any administrative review should be noted here by the signature of the reviewer, grade and date. Also indicate the number of attached sheets if applicable.
86	(Waiver Granted)	Indicate if a waiver was granted, date and by whom.
87	(Number of attached Sheets)	List the number of any attached sheets needed.

Note:

[1] Not all items are required on all examinations. See paragraph 8–12 to determine the scope of the examination based on the purpose of the examination.

[2] Note on the DD Form 2808, items 17 though item 39, the examiner must check normal, abnormal or NE (not examined). All abnormalities will be described in item 44 and continued in items 73 and 77 if needed.

[3] On page two of the DD Form 2808, re-enter the name and social security number of the examinee in the spaces provided.

[4] On page three of the DD Form 2808, re-enter the name and social security number of the examinee in the spaces provided.

Table 8–2
Schedule of separation medical examination or separation physical assessment*

Action	Medical examination required	Separation health assessment	Not required; can be requested by Soldier (in writing)
Retirement after 20 years or more of active duty	X		
Retirement from active service for physical disability, permanent or temporary, regardless of length of service.	X		
Expiration of term of active service (separation or discharge, less than 20 years of service).			X
Upon review of health record, evaluating physician or physician assistant at servicing MTF determines that, because of medical care received during active service, medical examination will serve the best interests of Soldier and Government: for example, hospitalization for other than diagnostic purposes within 1 year of anticipated separation date.	X		
Individual is member of the ARNGUS on active duty or ADT in excess of 30 days.		X	
Individual is member of the ARNGUS and has been called into Federal service (see paragraph 8–24*c)*.		X	
Prisoners of war, including internees and repatriates, undergoing medical care, convalescence or rehabilitation, who are being separated.	X		
Officers, warrant officers, and enlisted Soldiers previously determined eligible for separation or retirement for physical disability but continued on active duty after complete physical disability processing (AR 635–40, chapter 6, and predecessor regulations).	X (Plus MEB and PEB)		
Officers, warrant officers, and enlisted Soldiers being processed for separation under other than honorable (OTH) conditions meeting the criteria in paragraph 8-24*a*(3).	X		
Officers and warrant officers being processed for separation under provisions of specific sections of AR 600–8–24 that specify medical examination and/or mental status evaluation.	X		
Officers and warrant officers being processed for separation under provisions of specific sections of AR 600–8–24, when medical examination and/or mental status evaluation is not a requirement.			X
Enlisted Soldiers being processed for separation under provisions of AR 635–200, chapter 5: paras 5–3 (involuntary separations only), 5–11, 5–12, and 5–17 only, and chapters 8, 9, 11 (para 11–3*b* only), 12, and 18.		X	
Enlisted Soldiers being processed for separation under provisions of AR 635–200, chapters 13 and 14 (sec III only), (both mental evaluation and medical examination required).	X		
Enlisted Soldiers being processed for separation under provisions of AR 635–200, chapter 10. (If a medical examination is requested by the Soldier, then mental status evaluation is required.)			X
Discharge in absentia (officers and enlisted Soldiers):			X
Civil confinement.		X	
When a bad conduct discharge, or a dishonorable discharge, is upheld by appellate review and the individual is on excess leave.		X	
Deserters who do not return to military control.			X
Enlisted Soldiers being processed for separation under all other provisions of AR 635–200 not listed above.			X

Note:

[1] See paragraph 8–23 for additional information on medical examinations for separation/retirement.

Table 8–3
Results of Speech Recognition in Noise Test (SPRINT)

Categories and Recommendations	
A B	Retention in current assignment. Retention in current assignment with restrictions.
C	Reassignment to, or retention in, non–noise hazardous area of concentration (AOC)/MOS.
D	Discretionary. (The audiologist should make a recommendation of Category C or E based on such factors as stability of loss, potential for further noise exposure, the Soldier's AOC/MOS, and the recommendation of the Soldier's commander. However, if the Soldier has 18 or more years of active Service, the audiologist may recommend Category B.)
E	Separation from service.

Table 8–4
USPSTF Recommendations with modifications in accordance with this regulation

Test/Exam	Recommended start age or other criteria	Requirements/Recommendations/Other Clinical Considerations
Mammography	40, then every 1–2 years	Performed with/without clinical breast examination.
Cervical Cancer Screening	BCT/AIT	US Army requirement is for Annual Paps.
Colorectal Cancer Screening	50	Screen all starting at age 50.
High Blood Pressure Screening and HT/WT	BCT/AIT	Screen all at every medical encounter.
Lipid Disorder Screening – Males	35	Screen every 5 years and treat abnormal lipids.
Lipid Disorder Screening – Females	40	Screen every 5 years and treat abnormal lipids.
CV disease risk	40	Screen every 5 years or more often depending on risk, discuss ASA prophylaxis.
Osteoporosis Screening for postmenopausal women	60	For women at high risk for fractures, USPSTF recommends that screening begin at age 60
Chlamydia Screening	Sexually Active Females - Routinely	Screening all active duty females younger than 25, and other asymptomatic women at increased risk for infection. Cervical specimen is not necessary for women not due for an annual Pap smear. Urine test is acceptable.
Gonorrhea Screening	Sexually Active Females-Routinely	Screening all active duty females younger than 25, and other asymptomatic women at increased risk for infection. Cervical specimen is not necessary for women not due for an annual Pap smear. Urine test is acceptable.
Depression	18	In clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up.
Alcohol Misuse Screening	18	All adults, including pregnant women.
Tobacco Use	18	All adults, including pregnant women.

Chapter 9
Army Reserve Medical Examinations

9–1. General
This chapter sets basic policies and procedures for medical examinations and the periodic health assessment.

9–2. Application
a. This chapter applies to the following personnel:

(1) Applicants seeking to enlist or be appointed as commissioned or warrant officers in the USAR. (Medical examinations for entrance into the Army ROTC program are governed by AR 145–1 and AR 145–2.)

(2) USAR members who want to be kept in an active Reserve status.

(3) USAR members who want to enter ADT and active duty.

b. This chapter does not apply to the Active Army or the ARNG/ARNGUS.

9–3. Responsibility for medical fitness
a. It is the responsibility of RC Soldiers to maintain their medical and dental fitness. This includes correcting remedial defects, avoiding harmful habits, and controlling weight. RC Soldiers are responsible for seeking medical advice and

treatment quickly when they believe their physical wellbeing is in question. RC Soldiers must report to their unit commander, any change in their health status that impacts on their readiness status.

b. All RC Soldiers are responsible for providing the unit commander all medical documentation, including civilian health records, and completing the annual physical health assessment. Civilian health records documenting a change which may impact their readiness status will be placed in the Soldier's military health record.

9–4. Examiners and examination facilities

a. Applicants with prior service and RC Soldiers must present a letter of authorization to MEPS or Army medical facilities to receive a medical examination. (Applicants for initial enlistment who do not have prior military service will be examined only at MEPS.)

b. See paragraph 8–7*b* for examination facilities.

9–5. Examination reports

For all examinations, the examiner will prepare and sign two copies each of DD Form 2808 and DD Form 2807–1. The examining facility will keep one set of these reports. The medical examiner will send the other set of these reports to the commander who authorized the examination. The authorizing commander will then handle these two reports as follows.

a. Reports prepared in examinations for appointment will accompany the application for appointment per AR 135–100.

b. Reports prepared in examinations of ready Reservists will be sent to the unit administrator. If the examination was not accomplished at a military medical facility or at the MEPS, the reports will then be sent to the review authorities named in paragraph 9–9. After review, they will be returned to the unit administrator to be filed in the Reservist's health record. (To ensure against loss, the unit administrator should keep a copy of the reports when sending them for review.)

9–6. Conduct of examinations

a. Conduct of examinations and the periodic health assessment.

b. See paragraph 8–14 for validity periods for medical examinations and the periodic health assessment.

9–7. Types of examinations and their scheduling

a. For annual physical health assessments and other examinations, including Special Forces, see chapter 8.

b. Ready Reservists released from active duty or ADT must take their first periodic examination in accordance with paragraph 8–20*d*(5).

c. Commanders are responsible for taking proper corrective action whenever obligated Ready Reservists fail to accomplish their required annual health assessments and other examinations. Commanders are responsible to ensure the Soldier's readiness and medical status is properly documented in the personnel systems and the appropriate follow-up action is taken in regards to the Soldier's medical or readiness status.

9–8. Physical profiling

a. Examiners will determine and record physical profiles for Reservists per chapter 7.

b. Profiling officers should be available within USAR medical units.

9–9. Examination reviews

Review of periodic examinations for RC Soldiers not on active duty is normally not required if the examination is accomplished at Army medical facilities or MEPS. Chief, USAR or his or her designee may initiate additional reviews if appropriate. (See chap 6 for aviation reviews and chap 1 for all other reviews and waiver authorities.)

9–10. Disposition of medically unfit Reservists

a. Normally, Reservists who do not meet the fitness standards set by chapter 3 will be transferred to the Retired Reserve per AR 140–10 or discharged from the USAR per AR 135–175 or AR 135–178. They will be transferred to the Retired Reserve only if eligible and if they apply for it.

b. Reservists who do not meet medical retention standards may request continuance in active USAR status in accordance with paragraph 9–11 below. In such cases, a medical impairment incurred in either military or civilian status will be acceptable; it need not have been incurred only in the LOD. Reservists with nonduty related medical conditions who are pending separation for not meeting the medical retention standards of chapter 3 may request referral to a PEB for a determination of fitness in accordance with paragraph 9–12 below.

9–11. Requests for continuation in the USAR

a. Requests for continuance will include—

(1) A copy of the most recent periodic medical examination or PHA.

(2) Any additional medical examinations, consultations, and hospitalization or treatment records pertaining to the unfitting condition. Civilian records are acceptable.

(3) A summary of the Reservist's experience and qualifications.

(4) An evaluation by the Reservist's unit commander of the Soldier's potential value to the military Service and the ability of the Soldier to perform the duties of his or her primary MOS and grade.

b. Requests for continuance will be sent to the Commander, AHRC, who will consider each request and determine if the Reservist's experience and qualifications are needed in the Service.

c. Each request for continuance will also be reviewed by the Surgeon, AHRC; he or she will determine if—

(1) The disability may adversely affect the Reservist's performance of active duty. The Reservist's grade, experience, and qualifications must be considered when determining this.

(2) The rigors of active service would aggravate the condition so that further hospitalization, time lost from duty, or a claim against the Government might result.

d. Waivers requested for officers being considered for assignment/selection to and within the general officer grades will be sent to the Chief, USAR for review and final determination. The Chief, USAR will consider each request and determine if the Reservist's experience and qualifications are needed in the Service. Each request will be reviewed by TSG, who will determine whether—

(1) The disability may adversely affect the Reservist's performance of active duty as a general officer (07 and above).

(2) The rigors of active service would aggravate the condition so that further hospitalization, time lost from duty, or a claim against the Government might result. The Chief, USAR must consider TSG's review when making a final determination.

(3) Cases where the opinions of TSG and Chief, USAR differ concerning officer(s) being considered for assignment/promotion to and within general officer ranks will be forwarded to ODCS, G–1, ATTN: DAPE–GO, 300 Army Pentagon, Washington, DC 20301–0300 for final determination.

9–12. Request for PEB evaluation

a. RC Soldiers with non-duty related medical conditions who are pending separation for failing to meet the medical retention standards of chapter 3 of this regulation are eligible to request referral to a PEB for a determination of fitness. Because these are cases of RC Soldiers with non-duty related medical conditions, MEBs are not required and cases are not sent through the PEBLOs at the MTFs. Once a Soldier requests in writing that his or her case be reviewed by a PEB for a fitness determination, the case will be forwarded to the PEB by the USARC Regional Support Command or the AHRC Command Surgeon’s office and will include the results of a medical evaluation that provides a clear description of the medical condition(s) that cause the Soldier to not meet medical retention standards.

b. All obligated RC participants in the Health Professions Scholarship Program (HPSP) or Financial Assistance Program (FAP) with non-duty related medical conditions who are pending separation for failure to meet medical retention standards of chapter 3 of this regulation will receive a mandatory referral to a PEB for a fitness determination. Once an HPSP or FAP participant is mandatorily referred to a PEB, the case will be forwarded to the PEB by the USARC Regional Support Command or the AHRC Command Surgeon's office and will include the results of a medical evaluation that provides a clear description of the medical condition(s) that cause the Soldier to not meet medical retention standards.

9–13. Disposition of Reservists temporarily disqualified because of medical defects

a. Normally, Ready or Standby Reservists temporarily disqualified because of a medical defect will be transferred to the Standby Reserve inactive list (AR 140–10). Transfer will be made if—

(1) The Soldier is not required by law to remain a member of the Ready Reserve.

(2) The Soldier is currently disqualified for retention in an active USAR status.

(3) The condition is considered to be remediable within 1 year from the date disqualification was finally determined.

b. When determined by the Commander, AHRC, to be in the best interest of the service, temporarily disqualified Reservists may be transferred to or kept in the Standby Reserve for 1 year. This will not be done if the Reservist requests discharge from the USAR or transfers to the Retired Reserve.

c. Reservists who by law must remain members of an RC and whose medical defects are considered to be remediable within 1 year from the date of disqualification will be kept in an active status for 1 year. These reservists will be reassigned to the USAR control group (standby).

d. Reservists who are temporarily disqualified will be examined no later than 1 year from the date of transfer. Those found qualified will be transferred back to the USAR status they held before they were disqualified. See AR 140–10, AR 135–175, and AR 135–178 for disposition of those found disqualified.

9–14. Annual dental examinations

a. Members of the Selected Reserve shall receive an annual oral evaluation to determine their dental classification. This annual oral evaluation will be recorded in MEDPROS at Point of Service (POS).

b. An annual oral examination shall be performed according to DOD Guidelines for a Periodic Oral Evaluation or the American Dental Association (ADA) procedure code D0120. This examination will consist of a clinical evaluation of the oral cavity supported by bitewings and a panographic x-ray.

(1) The frequency of prescribing radiographs is based upon the clinical judgment of the Soldier's dentist and existing practice guidelines. (for example, HHS Publication No. FDA 88–8273). Radiographs shall be of diagnostic quality, properly identified, dated and placed in the military dental record.

(2) A panographic radiograph of adequate quality for diagnostic and forensic identification purposes is required in the dental record. There is no time requirement on updating panographic radiographs. However, the panographic radiograph must adequately represent the current oral condition of the Soldier. Soldiers shall have a panographic x-ray taken during initial dental processing. A new panographic x-ray shall be taken after extensive dental treatment.

(3) Digital x-rays are acceptable if they are a JPEG file and can be printed with approximately the size, resolution and diagnostic quality of a regular x-ray.

c. When the annual oral examination is performed by a civilian dentist, the examination shall be documented on a DD Form 2813 (Department of Defense Active Duty/Reserve Forces Dental Examination). Authorized medical/dental personnel will validate each examination and ensure accurate recording of the dental information on the DD Form 2813, SF 603 (Medical Record - Dental) and SF 603A (Medical Record - Dental –Continuation) is in the dental record. An entry on the SF 603/603A must include a statement indicating the use of DD Form 2813 as verification of dental examination and the examination information. Every effort should be made for the civilian dentist to provide copies of dental radiographs used in the examination process.

d. Personnel performing the annual oral examination have an obligation to inform the Soldier if he/she observe or are apprised of any signs or symptoms for which the Soldier should obtain further evaluation or dental care.

e. Military dental record requirements: (No dental record is considered complete unless the documentation is complete and in the proper order as outlined in TB MED 250)—

(1) Military dental record jacket DA Form 5570 (Health Questionnaire for Dental Treatment);

(2) DD Form 2005 (Privacy Act Statement Health Care Records);

(3) SF 603/603A;

(4) DD Form 2813;

(5) Health Insurance Portability and Accountability Act notice of privacy practices acknowledgment label. The HIPPA notice of privacy practices is not a required dental record document by the Army Reserve. However, the HIPPA notice of privacy practices form will be provided to all Army Reserve Soldiers during their first encounter with the Active Component Dental system at the dental treatment facility or at the mobilization station.

Chapter 10
Army National Guard

10–1. General

This chapter sets basic policies, standards, and procedures for medical examinations and physical standards for the ARNG/ARNGUS. The Clinical Section, Office of the Chief Surgeon, (NGB–ARS), is the office responsible for management of all issues pertaining to this chapter.

10–2. Application

This chapter applies to all ARNGUS Soldiers even when administered or operating in their status as members of the ARNG.

10–3. Medical standards

a. Chapter 2 standards apply to all initial enlistments, inductions, and appointments.

b. See AR 135–18 for the medical standards for entry into the AGR program.

c. Chapter 3 standards apply to retention in the ARNG/ARNGUS.

10–4. Entry into AGR (Title 10/32) Program

a. Soldiers who apply to enter the AGR (Title 10/32 Program) must meet chapter 3 medical retention standards. Pregnancy is not a disqualifying condition.

b. There are no waivers for entry into the AGR Program in accordance with paragraphs 2–1*d*, and 2–2.6 and table 2–3 in AR 135–18.

10–5. Active duty for more than 30 days (other than Title 10/32 AGR)

Prior to initiating active duty orders for more than 30 days, the National Guard Soldier must have a valid periodic health assessment (within one year) and must have no outstanding medical issues that require followup, to include a temporary profile (DA Form 3349). If the PHA is expected to expire during the deployment or time of activation, a new PHA must be completed within 60 days prior to the start of the period of active duty.

10–6. Re-entry on active duty or FTNGD

a. A Soldier may re-enter active duty, if the break in active duty service is less than 180 days from a previous period of active duty, by completing the PHA process and meeting the medical retention standards published in chapter 3 of this regulation. The break in service must be for non-medical reasons. If the break in service was for medical reasons, a chapter 2 physical examination must be completed.

b. All female Soldiers will be required to undergo pregnancy testing within 15 days prior to initiation of any active duty or any type of full time National Guard Duty (FTNGD) exceeding 30 days (except entry into the AGR program). Standard pregnancy tests performed by an accredited medical laboratory are acceptable. Pregnancy is a disqualifying factor for entry onto any active duty greater than 30 days except as noted.

10–7. Applications for Federal Recognition

Applications for Federal Recognition will include a current DD Form 2808 and DD 2807–1, within 2 years of the board action. Report of Medical Examination must indicate that Soldier meets the standards of chapter 2 for initial appointment, or has received a waiver from the approving authority.

10–8. General officer medical examinations

a. All ARNG/ARNGUS general officers will undergo a medical examination every 2 years, within 3 calendar months before the end of the officer's birth month. Examinations will be accomplished at any active MTF capable of completing these examinations or through nationally approved contractors capable of completing a medical examination.

b. All general officers will complete a PHA every 2 years, on the year opposite the medical examination, within 3 calendar months before the end of the general officer's birth month. (See para 8–20.) The PHA may be completed at any Active Army (AA) or RC MTF capable of completing a PHA. If the privileged provider completing the PHA indicates a need for further evaluation or medical treatment, the general officer will be referred to his/her civilian medical provider.

c. A copy of each completed physical examination or PHA will be forwarded to Chief, National Guard Bureau, ATTN: NGB–GO–AR, Room 2D366, The Pentagon, Washington, DC 20310–2500. NGB–GO–AR is responsible for forwarding completed general officer physical examinations to NGB–ARS for medical review.

d. Physical examinations for promotion to general officer will be obtained at Active Army MEDDAC or MEDCEN facilities, within the 6 months prior to the date of the convening selection board.

10–9. Immunizations

a. Immunization records will be reviewed and required immunizations will be administered in accordance with AFJI 48–110/AR 40–562/BUMEDINST 6230.15/CG COMDTINST M6230.4E. For Army Special Operations, USASOC Supplement 1 to AFJI 48–110/AR 40–562/BUMEDINST 6230.15/CG COMDTINST M6230.4E applies.

b. All administered immunizations will be immediately documented in MEDPROS and on DD Form 2766. MEDPROS is the HQDA standard for tracking all individual medical readiness indicators for the all COMPOS.

10–10. Periodic medical examinations

a. The periodic (every 5 years) medical examination has been replaced by the annual requirement for a PHA. (See para 10–8 for periodic examinations for general officers.) The annual PHA does not rescind the requirements for medical examinations for specific military training programs/schools. Cardiovascular screening will be accomplished at the first regularly scheduled PHA at age 40 years.

b. The requirements for physical examinations for schools, for commissioning or appointment, or other special purposes remain the same.

c. Flying personnel examinations will be in accordance with chapters 4 and 6 of this regulation and USAAMA policy and guidance.

10–11. Waivers

a. Chapter 3 medical retention standards are not waiverable for induction or accession.

(1) ARNG/ARNGUS Soldiers who do not meet chapter 3 retention medical standards will be processed in accordance with AR 600–60 (MMRB), AR 40–400 (MEB), and AR 635–40 (PEB) (as appropriate).

(2) Final determination of medical qualification will be made by the Chief, NGB (NGB–ARS), except where the authority for determination has been delegated to the State Adjutants General or reserved to the Active Army.

b. Requests for waivers will include a detailed medical evaluation or consultation concerning the physical defect, and complete justification for the request for waiver. Only waivers submitted through the Guard Electronic Medical Records (GEMR) system (or other designated electronic system) will be accepted for review by NGB–ARS. The justification will include statements indicating service experience, MOS or position to be placed in, any known specific hazards of the position, the benefit expected to accrue from the waiver, and a recommendation of the State Surgeon. A waiver will not be recommended for medical conditions that are subject to complications or aggravation by reason of military duty.

c. Waivers for aviators, FSs, ATCs, and flight medical aidman, and final determination of medical fitness for flying duty will be made by the Chief, NGB (NGB–AVN–OP), with consideration of recommendations made by the Director, USAAMA, Fort Rucker, AL, in accordance with chapters 4 and 6 of this regulation.

d. Waivers for initial training in Airborne, Ranger, Special Forces, Military Free Fall (MFF), and Diving will not be approved/granted except on the recommendation by the Commander of the appropriate proponent school.

10–12. Profiling

a. All profiles (temporary and permanent) will be documented in the Medical Operational Data System (MODS) within the Medical Non-Deployable Module (MND) or any other approved electronic profiling database system.

b. Profiles will be accomplished in accordance with chapter 7 with the additional requirement that all permanent profiles (1–4) must have two signatures.

c. The State Surgeon or physician designee shall be the profile approval authority (see para 7–6*c*) for their respective state.

10–13. Individual responsibility

a. Each ARNG/ARNGUS Soldier is individually responsible for the maintenance of his or her medical, physical, and mental fitness. This includes correcting remediable defects, avoiding harmful habits, and weight control.

b. The maintenance of good strength and aerobic conditioning is of prime importance to the modern Soldier. The completion of the APFT and the ability to perform the Soldier's MOS duties are the minimum level of fitness expected from the ARNG/ARNGUS Soldier (see FM 21–20).

10–14. Significant incident reporting responsibility

a. Soldiers' responsibilities include seeking medical advice quickly when they believe their physical well-being is in question. Any hospitalization, significant illness, or disease that occurs when not on duty will be reported to the unit commander or first sergeant at the earliest possible opportunity and, in all cases, before initiating the next period of training.

b. Documentation of significant medical events which have occurred since the last period of duty or which may limit duty performance should be provided to the unit administrator for inclusion into the Soldier's health record before the next period of duty. A profile assessment by a military provider should also occur before the next period of duty.

c. Documentation will also be placed into MODS, the Health Readiness Record (HRR) or other designated electronic database as a permanent electronic record of any significant medical events.

10–15. Duty restrictions

a. Any recommendation for restricted activity that has been made by a private physician will be reported in writing, before performing any duty.

b. It is the individual Soldier's responsibility to report any medical problems immediately to the chain of command and to comply with medical restrictions. Commanders will honor the private physician's recommendations until the Soldier is evaluated by a military provider, and a recommended course of action is determined by a profiling officer (see para 7–6).

c. Soldiers and commanders will abide by the medical restrictions and limitations documented on any profile (DA Form 3349) issued.

10–16. Authorization for examinations

a. *Examination authorization letter.* Soldiers entitled to medical examinations will be given a letter of authorization by the appropriate commander in accordance with instructions issued by the State Adjutant General. The letter will cite

the examinee's name, grade, social security number, organization, purpose of the examination, and other instructions as appropriate regarding payment for the examination and distribution of the completed medical examination.

b. *Issuing of orders for examinations.* Issuing of orders for examinations. Soldiers undergoing examinations are to be placed on orders if not otherwise in a duty status at the time of the examination.

c. *Travel expenses.* Travel at Government expense will be authorized if the examination facility is outside of the established local commuting area of the Soldier's residence. The examination should be scheduled so that travel, examination, and return home can be accomplished in 1 day. If additional time is required, the Soldier will be reimbursed for meals and lodging in accordance with Joint Federal Travel Regulation (JFTR). Government meals and lodging will be used if available. A certificate of non-availability must be submitted with claims for reimbursement.

d. Medical readiness funds are not authorized to be used for payment of travel and per diem for medical appointments or examinations.

10–17. Examination authorities

a. Nonprior service and prior service disability separated/retirement applications.

(1) Applicants who are not prior service, or who have had medical, physical, or disability separations/retirements from prior service, or who are Soldiers of the ARNG/ARNGUS who re-enter active duty under the split training option, or who are ARNG/ARNGUS Soldiers who re-enter active duty to complete IDT will be examined only at MEPS or other authorized agency. In cases of applicants who have been previously separated for medical reasons, all prior service medical documentation, records, and medical separation board proceedings will be made available to the MEPS prior to scheduling the examination.

(2) Applicants who have a service-connected disability as determined by the VA, even though not separated for medical reasons, will be restricted to MEPS processing. VA disability determination proceedings will be made available to MEPS prior to scheduling the examination.

b. AGR/other full time duty, fitness for duty/physical profile board determination examinations.

(1) Fitness for duty of AGR and other active duty ARNGUS Soldiers will be accomplished only at Active Army MTFs.

(2) Permanent profiles issued at other than Army facilities will be submitted to the overseeing Army MTF or NGB–ARS, together with all pertinent examination and treatment records, for review, approval, and translation to Army standards.

c. Other agencies authorized to perform examinations. All other medical examinations may be accomplished by any of the following components, agencies, or civilian physicians, in order of priority. AGR will use Active Army facilities, if available in reasonable commuting distance to duty location.

(1) ARNG/ARNGUS medical staff as outlined in paragraph 8–7*a*.

(2) Other military medical units or facilities, ARNG/ARNGUS, Active Army, or other RC having the technical capability of performing the examinations.

(3) MEPS, on a space available basis.

(4) VA medical facilities.

(5) United States Public Health Service facilities.

(6) Contracted civilian physicians legally licensed to practice medicine in the State concerned.

10–18. Examination review requirements/quality assurance

Examinations accomplished at facilities other than MEPS and Active Army facilities will be reviewed by the State Approving Authority or Physician Designee for quality assurance, to include AGR personnel physical examinations for other than initial accession into the AGR program. The reviewer will ensure the PULHES profile is in accordance with chapter 7 and table 7–1, that the DD Form 2808 is in accordance with chapter 8, and that medical standards used to qualify or disqualify the applicant or Soldier are in accordance with the applicable chapter (for example, chap 2 or chap 3) for the program or purpose for which the examination was completed. The purpose of examination must be clearly noted. The examination must be approved and signed by the reviewing officer.

10–19. Scope of medical examinations

a. *Change from original purpose of examination.* In the event a physical examination is to be employed for other than the original stated purpose for which it was performed, the examining privileged provider will enter a note in block 73. Any additional procedures after the original date of the examination will be entered in the appropriate block on the DD Form 2808 and initialed and dated by the exam provider. An entry will be made in block 73 listing all additional items accomplished, dated, signed, and stamped with the provider's identification information.

(1) When a physical examination has been modified from its original purpose, the date of the modification cannot exceed the validity time prescribed in paragraph 8–14. (Example: Physical exam performed in January 2002. In January

2004 the examination was modified for Ranger School. This would be invalid because the validity time for a Ranger School exam is 18 months.)

(2) The following is an example of an acceptable entry in block 73: "DATE. This examination has been reviewed by chapter 2 standards. All required items completed and listed appropriately. PULHES: 111121. Individual Qualified or Not Qualified. Signature."

b. *Required specialty consultations.* If additional examinations or specialty consultations beyond the capabilities of the examining facility are required, the State Medical Detachment will be notified. An SF 513 (Medical Record (Continuation Sheet)) will be completed by the requesting physician and furnished to the Soldier. The Soldier will be required to provide the completed SF 513 to the State Medical Detachment for completion of required consultations. Consultations and further examinations will be at the Soldier's expense unless otherwise noted.

c. *Occupational Medicine Exams.* DOD 6055.5–M, Occupational Medical Surveillance Manual, outlines minimum standard for establishing medical surveillance programs. Per DOD 6055.5–M paragraph C1.5.2.1, "Local occupational medical personnel establish examination content and frequency based on an understanding of the job demands, exposures to the workers, the medical effects of specific exposures, the impact of specific medical conditions on job performance and safety and legal and regulatory requirements."

10–20. Report of medical examinations

DD Form 2808 and DD Form 2807–1 and all continuation pages, and consultations will be submitted as follows:

a. The original will be forwarded directly to Medical Records Custodian for the following actions:

(1) A copy will be placed into the Soldier's health record.

(2) A copy will be scanned into MODS Health Readiness Record (HRR).

b. A copy will be maintained at the examination facility.

c. A copy will be furnished to the individual as required for schools, promotions, and other administrative actions in accordance with regulation and policy.

d. Copies will be made available for Enlistment and Re-enlistment as prescribed by NGR 600–200.

10–21. Directed examinations

The Chief, NGB, the State Adjutant General, the commanding officer of a Soldier's unit, or a medical officer may direct the Soldier to undergo a medical examination in accordance with AR 600–20 whenever, in the authority's opinion, the Soldier's medical, physical, dental or mental condition is such that an examination is indicated.

10–22. Administrative information

a. Any Soldier without a current PHA will not attend IDT or AT.

b. HIV testing will be completed in accordance with AR 600–110.

c. A special medical examination is not required for attendance at an Army service school, except as indicated below.

10–23. Special examinations

a. *Command and General Staff Course (Resident) and the regular course at the United States Army War College.* A MEDPROS print-out that shows that the PHA has been accomplished within the preceding 12 months will be forwarded with the school application to the school proponency at NGB. Chapter 3 medical standards for retention apply for physical examination review.

b. *Entry into Active Army OCS, State OCS, Warrant Officer Candidate School, and Airborne, Ranger, or Pathfinder training.* A complete physical examination (DD Form 2808 and DD Form 2807–1) is required, in accordance with chapters 2, 5, and 8 of this regulation, and will be accomplished within the preceding 24 months prior to the first day of school attendance. A PHA will be accomplished within 60 days preceding the start of school.

c. *Initial flight training course.* Physical examinations will be accomplished and approved in accordance with chapters 4 and 8 of this regulation prior to submission to NGB–ARO–TI.

d. *Special Forces initial qualification, MFF, and Combat Diver examinations.* Physical examinations will be accomplished and approved in accordance with paragraph 8–25 prior to submission to NGB–ARS.

10–24. Cardiovascular Screening Program (AGR Soldiers)

a. The CVSP for Title 10/32 AGR Soldiers will be conducted in accordance with paragraph 8–26 of this regulation with the PHA process.

b. Soldiers who do not obtain CVSP clearance will be medically flagged and processed through the MMRB in accordance with AR 600–60.

10–25. Soldiers pending separation for failing to meet medical retention standards

a. *Not in the Line of Duty (NILOD).* DODI 1332.38 states that members with non-duty related impairments are eligible to be referred to the PEB solely for a fitness determination, but not a determination of eligibility for disability benefits. Further explanation is available in TAPD-Policy Memorandum #4, Processing Reserve Component (RC) Non-Duty Related Cases. This policy memorandum outlines the procedures and requirements for processing boards on RC Soldiers with non-duty related impairments that are pending separation for medical disqualification. Determination of whether a non-duty case is forwarded to the PEB is at the request of the Soldier. The Soldier will have a completed LOD or memo that notifies him/her of non-duty related findings (Not In the Line of Duty -NILOD). The Soldier may not challenge the PEB findings in person.

(1) The Non-Duty PEB packet will include: the completed DA Form 2173 (Statement of Medical Examination and Duty Status) showing NILOD findings, DA Form 5889 (PEB Referral Transmittal Document) completed in accordance with TAPD-Policy Memorandum #4, ND–PEB Checklist with the following supporting documents: Soldier Notification of Pending Separation for Medical Disqualification, Soldier's Counseling of their right to a PEB, Soldier's election Letter, DA Form 3349, Fitness For Duty (FFD) examination with appropriate civilian/military consults, Commander's Statement on Duty Performance, DA Form 705 (Army Physical Fitness Test Scorecard) and any other evidence that the Soldier elects to provide.

(2) The MILPO is responsible for notifying the Soldier, in writing, that his/her injury is NILOD and that he/she is pending separation for a medical disqualifying condition. The notification will also advise the Soldier that he/she has the right to prepare a Non-Duty PEB packet for a fitness determination.

(3) The State Surgeon is responsible for completing the following: Physical Profile, a Fitness for Duty examination and obtaining the appropriate civilian consults from the Soldier (non-Duty related cases are the Soldier's responsibility and he/she must provide the appropriate medical consults from his/her civilian physician).

(4) The Commander is responsible for counseling the Soldier and completing a Commander's Letter of Duty Performance.

(5) The Soldier is responsible to request his/her packet be submitted to the PEB for adjudication. The Soldier is responsible for preparing his/her packet for submission to the PEB.

b. *In the Line of Duty (ILOD). Soldiers pending separation for ILOD injuries or illnesses will be processed in accordance with AR 40–400 and AR 635–40.*

10–26. Annual dental examination

a. Members of the Army National Guard shall receive an annual oral evaluation to determine their dental classification. This annual oral evaluation will be recorded in MEDPROS at Point of Service (POS).

b. An annual oral examination shall be performed according to DoD Guidelines for a Periodic Oral Evaluation or the American Dental Association (ADA) procedure code D0120. This examination will consist of a clinical evaluation of the oral cavity supported by bitewings and a panographic x-ray.

(1) The frequency of ordering radiographs is based upon the clinical judgment of the Soldier's dentist and existing practice guidelines. (e.g. HHS Publication No. FDA 88–8273). Radiographs shall be of diagnostic quality, properly identified, dated and placed in the military dental record.

(2) A panographic radiograph of adequate quality for diagnostic and forensic identification purposes is required in the dental record. There is no time requirement on updating panographic radiographs. However, the panographic radiograph must adequately represent the current oral condition of the Soldier. Soldiers shall have a panographic x-ray taken during initial dental processing. A new panographic x-ray shall be taken after extensive dental treatment.

(3) Digital x-rays are acceptable if they are a JPEG file and can be printed with approximately the size, resolution and diagnostic quality of a regular x-ray.

c. When the annual oral examination is performed by a civilian dentist, the examination shall be documented on a DD Form 2813. Authorized medical/dental personnel will validate each examination and ensure accurate recording of the dental information on the DD Form 2813 and SF 603/603A is in the dental record and in DENCLASS. An entry on the SF 603/603A must include a statement indicating the use of DD Form 2813 as verification of dental examination and the examination information. Every effort should be made for the civilian dentist to provide copies of dental radiographs used in the examination process.

d. Personnel performing the annual oral examination have an obligation to inform the Soldier if he/she observes or are apprised of any signs or symptoms for which the Soldier should obtain further evaluation or dental care.

e. Military dental record requirements: (No dental record is considered complete unless the documentation is complete and in the proper order as outlined in TB MED 250).

(1) Military dental record jacket DA Form 5570 (envelope);

(2) DD Form 2005 (Privacy Act Statement Health Care Records);

(3) SF 603/603A;
(4) DD Form 2813;
(5) Health Insurance Portability and Accountability Act notice of privacy practices acknowledgment label. The HIPPA notice of privacy practices is not a required dental record document by the ARNG. However, the HIPPA notice of privacy practices form will be provided to all ARNG Soldiers during their first encounter with the Active Component Dental system at the dental treatment facility or at the mobilization station.

10–27. Physical inspections prior to annual training

a. Unit commanders are responsible for individual inspection of all personnel under their command immediately prior to departure for AT (normally within 72 hours).

b. As a minimum, this screening will consist of—

(1) Confirmation that a current PHA is on hand for each Soldier scheduled to attend AT.

(2) Physical observation for any outward signs of existing injury or disease, including bandages, splints, casts, use of crutches, braces, or other orthopedic devices.

(a) Any Soldier that has not previously been evaluated or exhibits signs of an obvious physical, psychiatric, or dental condition that is likely to interfere with or be aggravated by AT will be required to be evaluated by a military medical officer, including the completion of a new PHA before being allowed to depart for AT.

(b) If this evaluation results in a determination of a significant category change, the Soldier may not attend AT until cleared.

c. The commander will certify in the remarks section of unit DA Form 1379 (U.S. Army Reserve Components Unit Record of Reserve Training) that the screening in b above took place before unit annual training, and will ensure that this certification includes his or her name, unit, and date. This statement will read: " I, the (Commander) of (Unit) performed a physical inspection of each Soldier present and attending annual training on (Date), prior to departing for unit annual training."

Chapter 11
Individual Medical Readiness Standards

11–1. General

This chapter implements Department of Defense Instruction 6025.19 and supplements the information provided in AR 220–1.

11–2. Purpose

a. The purpose of the chapter is to establish measurable medical elements as components of Individual Medical Readiness (IMR). Compliance will be monitored and reported on the AMEDD Balanced Scorecard. This compliance report includes all IMR data with the exception of Pap smear, Class 3 dental work, and additional series vaccinations.

b. The IMR program equips unit commanders and PCMs with the tools to monitor the IMR status of their personnel and patients, resulting in a healthy and fit fighting force medically ready to deploy.

c. The DoD requires quarterly reporting of the IMR status of Active and Selected Reserve members, except those Soldiers who have not completed initial military training (IMT) and follow-on technical skills training or others who are unavailable to deploy (for example, recruiters, ROTC cadre, students in deferred status pursuing advanced academic degrees).

d. The IMR program enables commanders and staffs at all levels to analyze and address key unit status medical indicators/elements.

11–3. Responsibilities

a. The unit status report (USR) is a commander's report. Unit commanders are solely responsible for the accuracy of the information and data they enter into their reports. Unit Commanders are responsible for monitoring their Soldiers' IMR status and ensuring compliance. Unit medical assets, when available, are primarily responsible for supporting medical readiness.

b. Regional Medical Command (RMC) Commanders will ensure MTFs provide the necessary medical care to Soldiers to ensure they meet the IMR standards. MTFs will assist commanders with supporting medical assets to maximize the number of personnel classified as fully medically ready (FMR) when unit medical assets are not available to supply necessary services.

(1) The MTFs providing medical care to Soldiers during Basic Combat Training will update the IMR status during initial in-processing.

(2) The MTFs will not refuse IMR related appointments for AC Soldiers enrolled in TRICARE Prime Remote. Soldiers on Active Duty status who are assigned to TRICARE Prime Remote may utilize the Reserve Health Readiness Program (RHRP) once a voucher process is established.

(3) All Soldiers out processing through an MTF are to be FMR, if possible, prior to clearing the MTF.

11–4. Individual Medical Readiness elements

The USR Personnel level is based on that portion of a unit's required strength that is available for deployment/employment with the unit to accomplish its wartime mission. The individual medical readiness (IMR) elements are one portion of the personnel level of the USR (see AR 220–1). The IMR consists of the following elements:

a. Health assessment.

(1) The Periodic Heath Assessment (PHA) will be considered the health assessment (HA) and is considered current if it has been less than 15 months since the last PHA. During months 1 through 11, the Soldier is considered "Green". From months 12 to 15, the Soldier is considered "Amber." At the 15th month since the last PHA, the Soldier will be considered "Red" (See para 8–20 of this regulation for PHA requirements).

(2) The HA consists of the date of the HA, height, weight, PULHES, and potential for deployablility within 6 months.

(3) The results of the PHA will be directly entered at the Point of Service (POS) into MEDPROS. MEDPROS PHA information (PULHES, profile codes, date of PHA and for RC, height and weight) will automatically update the information in the Total Army Personnel Database (TAPDB). The PULHES will be updated to reflect permanent profiles only.

(4) Deployed Soldiers are exempt from the PHA requirement until 90 days after returning from deployment. For the time period of 90 days until 180 days, the Soldier will be considered "Amber." If the Soldier does not update his PHA by the 180th day after his return from deployment, he will be considered "Indeterminate" and "Gray" in MEDPROS.

b. Deployment limiting medical conditions. Soldiers who will not deploy with the unit for various medical reasons will be considered medically not ready and categorized as "Red" in MEDPROS. Soldiers with deployment-limiting conditions are—

(1) Active duty Soldiers admitted as an inpatient to an MTF. These Soldiers are categorized as "absent sick status."

(2) Soldiers who are pregnant. Testing for pregnancy is not a routine requirement. Positive pregnancy tests must be manually posted into MEDPROS by the medical staff at the location where the test was obtained. A pregnant Soldier is not deployable and categorized as "Red" in MEDPROS.

(3) Soldiers with permanent (P3/P4) profiles unless they have been cleared for deployment by a MOS Medical Retention Board (MMRB) and/or have been found "fit for duty" by a PEB without any deployment limitations (or medically cleared to mobilize-RC only).

(a) Soldiers who completed appropriate board actions (MMRB, PEB) must have the appropriate Profile Code (from box 2 on DA Form 3349) entered into MEDPROS.

(b) Code "W" for MMRB complete, code "X" for COAD or COAR after the Soldier was found "unfit" by a PEB, or code "Y" after the Soldier was found "Fit for Duty" by a PEB. (See table 7–2 for complete list of codes).

(c) All physical profiles exceeding 30 days duration will be entered electronically in either AHLTA or the Medical Non-deployable Module (MNM) of MODS to improve visibility and management of the Soldiers with profiles.

(4) Personnel with a temporary (T3/T4) profile that cannot be medically cleared for deployment (includes prenatal and postpartum profiles according to para 7–9). The appropriate Profile Code(s), from box 2 on DA Form 3349, must be entered into MEDPROS.

(5) Soldiers assigned to Warrior Transition Units.

c. Dental readiness. (See AR 40–3, para 6–5 for complete information.)

(1) *Dental Class 1.* Soldiers with a current dental examination, who do not require dental treatment or reevaluation. Class 1 Soldiers are worldwide deployable and classified as medically ready and "Green" in MEDPROS.

(2) *Dental Class 2.* Soldiers with a current dental examination, who require non-urgent dental treatment or reevaluation for oral conditions which are unlikely to result in dental emergencies within 12 months. However, Dental Class 2 Soldiers still have active dental disease that will eventually require treatment. Dental Class 2 Soldiers are worldwide deployable, considered medically ready, and classified as "Green" in MEDPROS.

(3) *Dental Class 3.* Soldiers who require urgent or emergent dental treatment. Dental Class 3 Soldiers are normally considered medically not ready and are classified as "Red" in MEDPROS.

(4) *Dental Class 4.* Soldiers who require dental examinations. This includes Soldiers who require annual or other required dental examinations and Soldiers whose dental classifications are unknown. Dental Class 4 Soldiers are normally considered to be medically not ready and are classified as Indeterminate status and "Red" in MEDPROS.

d. Immunizations.

(1) Only the routine mandatory immunization (IM) profile (adult panel) is tracked and reported as part of the USR (see AR 40–562).

(2) Mandatory IMs for all Army personnel include—

(a) Hepatitis A – 2 doses at 0 and 6–12 months after the first injection or the Hepatitis A/Hepatitis B combined vaccine (Twinrix) – 3 doses at 0, 1 month and 6 month intervals.

(b) Tetanus/Diphtheria (Td) booster every 10 years or Tetanus/diphtheria acellular pertussis (Tdap) as a one time booster.

(c) An annual influenza immunization.

(3) All other adult immunizations will be maintained as per AR 40–562.

(4) Other immunizations will be given dependent on risk assessment for the country of deployment or Soldier's physical condition.

(5) The MTF or medical personnel who administered the vaccine to the Soldier are responsible for ensuring entry of the immunization data into MEDPROS or AHLTA. Unit commanders are responsible for ensuring that the Soldiers report to immunization clinics to obtain required immunizations.

(6) Soldiers are considered medically ready and "Green" if current on all mandatory immunizations. If the Soldier is missing one or more mandatory immunizations, the Soldier will be considered medically not ready and categorized as "Amber" in MEDPROS.

e. Deoxyribonucleic acid. A DNA specimen is obtained once and is on file at the Armed Forces DNA Repository.

(1) Soldiers with a DNA sample on file and recorded in MEDPROS are considered medically ready and categorized as "Green" in MEDPROS.

(2) Soldier will be considered as medically not ready and categorized as "Red" in MEDPROS if there is no evidence that a DNA specimen was drawn ("D" in MEDPROS) or if there is no evidence that a specimen is on file at the Armed Forces DNA Repository.

(3) If the DNA on file category in MEDPROS is blank, the Soldier is considered medically not ready and categorized as "Amber" in MEDPROS.

f. Current Human Immune Deficiency Virus. The Human Immune Deficiency Virus (HIV) antibody test as required by AR 600–110.

(1) Soldiers with a current HIV antibody test (and received at Army Medical Surveillance Activity (AMSA)) within 2 years are considered medically ready and categorized as "Green" in MEDPROS.

(2) Soldiers without a current HIV test (MEDPROS will default to incomplete after 30 days overdue) are considered medically not ready and categorized as "Red" in MEDPROS.

g. Hearing readiness.

(1) The Defense Occupational Environmental Hearing Readiness Application-Hearing Conservation (DOEHRS–HC) audiometer is the only authorized audiometer for conducting and recording DD Form 2215 (Reference Audiogram) and DD Form 2216 (Hearing Conservation Data).

(2) All military personnel will receive a DD Form 2215 at IET prior to noise exposure. (See DA Pam 40–501 for more information.)

(3) All Soldiers assigned to a TOE unit or who have a PROFIS assignment to a TOE unit must complete hearing readiness requirements to include an annual DD Form 2216.

(4) Hearing Readiness Categories are as follows:

(a) Hearing Class 1. Soldier has a current, within 12 months, DOEHRS–HC audiogram. Unaided hearing is within H–1 profile standards (see table 7–1). Soldier will be considered medically ready and categorized as "Green" in MEDPROS.

(b) Hearing Class 2. Soldier has current, within 12 months, DOEHRS–HC audiogram. Unaided hearing is within H–2 or H–3 profile standards and Soldier has a permanent profile recorded in MEDPROS for hearing. If Soldier requires hearing aid(s), he/she must have prescribed hearing aid(s) and a 6-month supply of batteries. Soldier will be considered medically ready and categorized as "Green" in MEDPROS.

(c) Hearing Class 3. Soldier has current, within 12 months, DOEHRS–HC audiogram. Unaided hearing is within H–2 or H–3 profile standards but the Soldier requires a complete audiological evaluation (Speech Recognition in Noise Test (SPRINT) is required) to document permanent hearing profile on DA Form 3349 or needs prescribed hearing aid(s). If the Soldier meets medical retention standards of chapter 3, AR 40–501, than he/she requires a MMRB. Soldier will be considered medically not ready and categorized as "Red" in MEDPROS.

(d) Hearing Class 4. Soldier requires a DOEHRS–HC audiogram. Soldier does not have a reference baseline audiogram or a current periodic audiogram. Soldier will be considered medically not ready and categorized as "Red" in MEDPROS.

h. Vision readiness. Visual acuity testing will not be done with the Soldier wearing contact lenses. The vision readiness categories are as follows:

(1) *Vision Class 1.* Soldier has corrected vision of 20/20 (with both eyes open), either with best spectacle correction or without spectacles. If spectacles are required, Soldier has a record of spectacle prescription recorded in MEDPROS. Soldier will be considered medically ready and categorized as "Green" in MEDPROS.

(2) *Vision Class 2.* Soldier has corrected vision between 20/25 and 20/40 or an accession waiver for vision worse than 20/45 (with both eyes open), either with best spectacle correction or without spectacles. If spectacles are required for the Soldier to achieve this visual acuity, the Soldier has a record of a spectacle prescription recorded in MEDPROS. Soldier's vision may require an update of their spectacle prescription and a referral to Optometry is recommended. Soldier will be considered medically ready and categorized as "Green" in MEDPROS.

(3) *Vision Class 3.* Soldier has best corrected vision worse than 20/45, or no spectacle prescription on record (if required), or the spectacle prescription is older than 4 years. Referral to Optometry is mandatory. Soldier will be considered as medically not ready and categorized as "Amber" in MEDPROS.

(4) *Vision Class 4.* Soldier has not completed a visual acuity screening the past 365 days or the vision data is incomplete. Soldier will be considered as medically not ready and categorized as "Amber" in MEDPROS.

i. Women's readiness.

(1) Female Soldiers are required to have an annual pap smear unless they meet one of the following criteria:

(a) If the Soldier is 30 years of age or older, has no past history of dysplasia and she has had 3 consecutive normal pap smears. These Soldiers are required to have a pap every 3 years.

(b) If the Soldier has had a hysterectomy for reasons other than cervical dysplasia or cancer, she is not required to have pap.

(2) Female Soldiers 25 years of age or younger are required to have annual Chlamydia testing.

(3) Women's Health Readiness Categories are as follows:

(a) Women's Class 1. Soldier has normal cervical cytology within 1 year; or those Soldiers, 30 years of age or older, who meet the criteria in (1)(a) and have had a normal cytology within 3 years. Soldier will be considered medically ready and categorized as "Green" in MEDPROS.

(b) Women's Class 2. This class includes Soldiers, 20 years of age and younger, who have a history of abnormal cervical cytology to include cytology showing Atypical Squamous Cells of Unknown Significance (ASC–US); Human Papilloma Virus (HPV) typing negative or positive for oncogenic HPV; Low-grade Squamous Intraepithelial Lesion (LGSIL) or Cervical Intraepithelial neoplasia (CIN) 1 (mild). This class also includes those Soldiers of any age with abnormal cervical cytology which has been fully evaluated and/or treated and they have been cleared for deployment by a provider credentialed in women's health. Soldier will be classified as medically ready and categorized as "Green" in MEDPROS.

(c) Women's Class 3. Soldier's most recent cervical cytology is abnormal and requires further evaluation by a gynecologist. For Soldiers 20 years of age and younger, the following cervical cytology results require further evaluation: High-grade Squamous Intraepithelial Lesion (HGSIL); CIN 2 (moderate), CIN 3 (severe), Carcinoma in situ (CIS), Adenocarcinoma in situ (AIS), AGC, or invasive cancer. For Soldiers over the age of 20 the following cervical cytology results require further evaluation: ASC–US; HPV Positive; LGSIL; HGSIL; any CIN grade; CIS; AIS; Atypical Glandular Cells (AGC); or invasive cancer. Soldier will be considered medically not ready and categorized as "Red" in MEDPROS.

(d) Women's Class 4. Soldier has not had a pap smear within the last 365 days; unless she falls in the categories described in paras (1)(a) and (b) of Women's Readiness. Soldier will be considered medically not ready and classified as "Red" in MEDPROS.

(4) The PCMs and unit commanders should counsel all female Soldiers about women's health during deployments. Unit commanders will ensure female Soldiers have access to a copy of "Female Guide to Readiness" available at http://chppm-www.apgea.army.mil/documents/tg/techguid/tg281draft29sepfinal.pdf.

(5) The PCMs should counsel all female Soldiers up to age 26 about the benefits of the HPV vaccine and offer the vaccine.

j. Pregnancy. Pregnancy testing should only be conducted within 30 days of deployment. A pregnant Soldier is categorized as "Red" in MEDPROS.

11–5. Individual Medical Readiness categories

After evaluating the Soldier in the 9 required elements, the Soldier will be categorized by MEDPROS into one of four medical readiness categories:

a. Medical Readiness Class 1 (MR1).

(1) All medical requirements met.

(2) Soldier is fully medically ready in all elements.

(3) Optical devices ordered.

(4) Soldiers categorized as “Green” in MEDPROS.

b. *Medical Readiness Class 2 (MR2).*

(1) Medically ready within 72 hours (any deficiencies correctable during final Soldier Readiness Program (SRP)).

(2) Deficiencies may include immunizations, Dental Class 2 conditions, lack of medical warning tags, need HIV or DNA lab tests, or optical prescription on file but eye equipment not ordered.

(3) Soldiers categorized as “Green” in MEDPROS.

c. *Medical Readiness Class 3A (MR3A).*

(1) Medically ready within 30 days.

(2) Deficiency may include Dental Class 3.

(3) This time frame allows for the medical treatment of abnormal screening tests.

(4) Includes deficiencies that are resourced through Transition Assistance Management Program (TAMP) for correction in alerted Selected Reserve Soldiers.

(5) Soldiers are categorized as “Red” in MEDPROS.

d. *Medical Readiness Class 3B (MR3B).*

(1) Medical requirements will take more than 30 days to correct.

(2) Deficiencies may include temporary profiles exceeding 30 days, and P3 or P4 profiles that require completion of a MMRB. (If the Soldier does not meet medical retention standards, Soldier requires a MEB.)

(3) Soldiers who are pregnant.

(4) Soldiers who are hospitalized (absent sick status).

(5) Soldiers found “Unfit” but continued in COAD status.

(6) Soldiers are categorized as “Red” in MEDPROS.

e. *Medical Readiness Class 4 (MR4).*

(1) Medical readiness requirement deficiencies are considered in an indeterminate status.

(2) Deficiencies may include:

(a) No current periodic health assessment (PHA).

(b) No current dental screen.

(3) Categorized as “Gray” in MEDPROS.

11–6. Disposition of Individual Medical Readiness data

a. The MEDPROS is the database of record for all medical readiness data elements.

b. All IMR data will be updated in MEDPROS for all Army personnel (all COMPOS), including deploying Department of the Army civilians, regardless of TRICARE enrollment.

c. Until bidirectional interfaces are functional, medical readiness services completed in AHLTA (with the exception of immunizations) must be updated in MEDPROS within 72 hours of completion. (This can be done through a single source sign on portal to Medical Operational Data System (MODS) that will be available with AHLTA 3.3).

d. The MEDPROS will automatically update the Army Status of Resources and Training System (ASORTS) database, which serves as the central registry and authorized database of record for all operational Army organizations and units. (In FY07, ASORTS will become the Defense Readiness Reporting System-Army (DRRS–A) database.)

Appendix A

References

Section I

Required Publications

APL series
Aeromedical Policy Letters (Cited in para 4–1*e*.) (Available at http://www.cs.amedd.army.mil/usasam/.)

AR 12–15
Joint Security Cooperation Education and Training (Cited in para 6–9*b*.)

AR 40–3
Medical, Dental, and Veterinary Care (Cited in para 6–4*a*.)

AR 40–29/AFR 160–13/NAVMEDCOMINST 6120.2/CG COMDTINST M6120.8
Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including Two- and Three-year College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS) (Cited in para 1–6*c*.)

AR 40–66
Medical Record Administration and Health Care Documentation (Cited in para 8–5*a*.)

AR 40–400
Patient Administration (Cited in para 3–3.)

AR 40–562/BUMEDINST 6230.15/AFJI 48–110/CG COMDTINST M6230.4E
Immunizations and Chemoprophylaxis for the Prevention of Infectious Disease (Cited in para 10–9*a*.)

AR 55–46
Travel Overseas (Cited in para 5–14*g*.)

AR 95–1
Flight Regulations (Cited in para 6–11*d*.)

AR 95–20/NAVAIRINST 3710.1F/AFJI 10–220/DCMA INST 8210.1/AFI 10–220/COMDTINST M13020.3
Contractor's Flight and Ground Operations (Cited in para 4–31*a*(2.).)

AR 135–18
The Active Guard Reserve (AGR) Program (Cited in para 10–3*b*.)

AR 135–100
Appointment of Commissioned and Warrant Officers of the Army (Cited in para 9–5*a*.)

AR 135–175
Separation of Officers (Cited in para 3–7*h*.)

AR 135–178
Enlisted Administrative Separations. (Cited in para 3–7*h*.)

AR 140–10
Assignments, Attachments, Details, and Transfers (Cited in para 3–7*h*.)

AR 145–1
Senior Reserve Officers' Training Corps Program: Organization, Administration, and Training (Cited in para 8–15*a*.)

AR 145–2
Organization, Administration, Operation, and Support (Cited in para 9–2*a*(1.).)

AR 385–10
The Army Safety Program (Cited in para 6–4*j*(4.).)

AR 600–8–24
Officer Transfers and Discharges (Cited in para 3–3*b*.)

AR 600–8–101
Personnel Processing (In-, Out-, Soldier Readiness, and Deployment Cycle) (Cited in para 5–14*g*.)

AR 600–8–105
Military Orders (Cited in para 6–17*f*(2.).)

AR 600–9
The Army Body Composition Program (Cited in para 2–21*a*.)

AR 600–85
Army Substance Abuse Program (ASAP) (Cited in para 4–23*h*(2.).)

AR 600–105
Aviation Service of Rated Army Officers (Cited in para 4–2.)

AR 600–106
Flying Status for Nonrated Army Aviation Personnel (Cited in para 4–2.)

AR 600–110
Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV) (Cited in para 3–7*h*.)

AR 601–270/AFR 33–7/MCO P–1100.75A
Military Entrance Processing Stations (MEPS) (Cited in para 8–4*a*.)

AR 608–75
Exceptional Family Member Program (Cited in para 5–14*d*.)

AR 611–110
Selection and Training of Army Aviation Officers (Cited in para 4–2*a*(1.).)

AR 614–30
Overseas Service (Cited in para 7–9*d* (1.).)

AR 614–200
Enlisted Assignments and Utilization Management (Cited in para 5–14*g*.)

AR 635–40
Physical Evaluation for Retention, Retirement, or Separation (Cited in para 2–2*c*(2)(*b*).)

AR 635–200
Active Duty Enlisted Administrative Separations

Assistant Secretary of Defense (Health Affairs) Policy Memorandum, Subject: Policy Guidance for Deployment–Limiting Psychiatric Conditions and Medications, dated 7 Nov 2006
(Cited in para 5–14*f* (8). Available at: http://www.health.mil/policies?daterange=2005–2009&query=deployment-limiting%20psychiatric)

ATB series
Aeromedical Technical Bulletins (Cited in para 4–1*c*. Available at http://www.cs.amedd.army.mil/usasam/.) (Cited in para 2–2*c*(2)(*a*).)

DA Pam 385–90
Army Aviation Accident Prevention Program (Cited in para 6–4*j*.)

DOD 6055.05–M
Occupational Medical Examinations and Surveillance Manual

DSM–5
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association (Cited in para 3–30*j*. This manual may be ordered at www.appi.org.) (Cited in para 10–19*c*.)

NATO STANAG 3526
Interchangeability of NATO Aircrew Medical Categories (Cited in para 4–1*c*. Available at http://www.nato.int/.)

TB MED 287
Pseudofolliculitis of the Beard and Acne Keloidalis Nuchae (Cited in para 7–3*e*(5.). Available at http://chppm-www.apgea.army.mil/tbm.htm.)

Section II

Related Publications

A related publication is a source of additional information. The user does not have to read a related publication to understand this regulation. Unless otherwise indicated, publications are available at www.apd.army.mil. DOD publications are available at http://www.dtic.mil/whs/directives. The United States Code and the Code of Federal Regulations are available at http://www.gpo.gov/fedsys.

AD 2016–30
Army Policy on Military Service of Transgender Soldiers

AR 40–5
Preventive Medicine

AR 40–8
Temporary Flying Restrictions Due to Exogenous Factors

AR 40–68
Clinical Quality Management

AR 135–91
Service Obligations, Methods of Fulfillment, Participation Requirements, and Enforcement Procedures

AR 135–133
Ready Reserve Screening, Qualification Records System and Change of Address Reports

AR 140–1
Mission, Organization, and Training

AR 140–185
Training and Retirement Point Credits and Unit Level Strength Accounting Records

AR 220–1
Army Unit Status Reporting and Force Registration—Consolidated Policies

AR 350–1
Army Training and Leader Development

AR 600–8–10
Leaves and Passes

AR 600–20
Army Command Policy

AR 600–60
Physical Performance Evaluation System

AR 601–210
Active and Reserve Components Enlisted Program

AR 611–75
Management of Army Divers

AR 614–10
Army Personnel Exchange Program With Military Services of Other Nations

AR 635–8
Separation Processing and Documents

AR 670–1
Wear and Appearance of Army Uniforms and Insignia

5 CFR Part 339
Medical qualification determinations

14 CFR Part 61
Certification: Pilots, flight instructors, and ground instructors

14 CFR Part 65
Certification: Airmen other than flight crewmembers

14 CFR Part 67
Medical standards and certification

DA Pam 40–501
Army Hearing Program

DA Pam 600–8
Military Human Resources Management Administrative Procedures

DA Pam 611–21
Military Occupational Classification and Structure

DFAS–IN Regulation 37–1
Finance and Accounting Policy Implementation. (Available at http://www.asafm.army.mil.)

DOD 7000.14–R, Vol 7A
Military Pay Policy and Procedures – Active Duty and Reserve Pay (Available at http://comptroller.defense.gov/fmr.aspx)

DODD 1308.1
DOD Physical Fitness and Body Fat Program

DODI 6130.03
Medical Standards for Appointment, Enlistment, or Induction in the Military Services

DODI 1332.14
Enlisted Administrative Separations

DODI 6025.19
Individual Medical Readiness (IMA)

DODI 6490.03
Deployment Health

MIL–PRF–680C
Degreasing Solvent (Available at http://assist.daps.dla.mil/quicksearch)

NGR 600–200
Enlisted Personnel Management (Available at Army Knowledge Online (AKO) https://search.us.army.mil/search)
NDAA **FY** 17 Section 524
National Defense Authorization Act FY 17

OPM Operating Manual
Qualifications Standards Handbook for General Schedule Positions (Available at http://www.opm.gov/)

Periodic Health Assessment
U.S. Army Implementation Plan, 12 October 2006 (Available at www.med.navy.mil/)

SECARMY Memo for the Commander, U.S. Army Cadet Academy
Delegation of authority for Cadet Medical Waivers and Medical Disqualifications, dated 21 Apr 2016

SECARMY Memorandum for the Superintendent, U.S. Military Academy
Medical Waiver Authority for Commissioning USMA Cadets, dated 6 Nov 2015

TB MED 507
Heat Stress Control and Heat Casualty Management

TB MED 250
Dental Record Administration, Recording, and Appointment Control

TB MED 523
Control of Hazards to Health from Microwave and Radio Frequency Radiation and Ultrasound

TB MED 524
Occupational and Environmental Health: Control of Hazards to Health From Laser Radiation

TC 3–04.8Individual Flight Records Folder Management (Available at https://www.us.army.mil/suite/login/welcome.html.)5 USC 552a(b)7
Public information; agency rules, opinions, orders, records, and proceedings

10 USC 10148
Ready Reserve: failure to satisfactorily perform prescribed training

10 USC 1177
Members diagnosed with or reasonably asserting post-traumatic stress disorder or traumatic brain injury: medical examination required before administrative separation

10 USC 10206
Members: physical examinations

10 USC 12301
Reserve components generally

10 USC 12302
Ready Reserve

10 USC 12303
Ready Reserve: members not assigned to, or participating satisfactorily in, units

10 USC 12304
Selected Reserve and certain Individual Ready Reserve members; order to active duty other than during war or national emergency

10 USC 12305
Authority of President to suspend certain laws relating to promotion, retirement, and separation

Section III

Prescribed Forms

Except where otherwise indicated below the following forms are available as follows: DA Forms are available on the APD Web site (http://www.apd.army.mil); DD Forms are available on the OSD Web site (http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm); and Standard Forms (SF) and Optional Forms (OF) are available on the GSA Web site (http://www.gsa.gov).

DA Form 3083
Medical Examination for Certain Geographical Areas (Prescribed in para 8–24*b*(5.).)

DA Form 3349
Physical Profile (Prescribed in para 3–24.)

DA Form 4497
Interim (Abbreviated) Flying Duty Medical Examination (Prescribed in para 6–7.)

DA Form 7349
Initial Medical Review—Annual Medical Certificate (Prescribed in para 8–19.)

DD Form 2697
Report of Medical Assessment (Prescribed in para 8–12.)

DD Form 2807–1
Report of Medical History (Prescribed in para 6–6.)

DD Form 2807–2
Medical Prescreen of Medical History Report (Prescribed in para 8–5*b*(1.).)

DD Form 2808
Report of Medical Examination (Prescribed in para 6–6.)

DD Form 2992
Medical Recommendation for Flying or Special Operational Duty (Prescribed in para 4–2*d.)*

Section IV

Referenced Forms

Except where otherwise indicated below the following forms are available as follows: DA Forms are available on the APD Web site (http://www.apd.army.mil); DD Forms are available at http://www.dior.whs.mil.

DA Form 11–2
Internal Control Evaluation Certification

DA Form 705
Army Physical Fitness Test Scorecard

DA Form 1379
U.S. Army Reserve Components Unit Record of Reserve Training (Available through normal supply channels.)

DA Form 2173
Statement of Medical Examination and Duty Status

DA Form 3725
Army Reserve Status and Address Verification

DA Form 4700
Medical Record—Supplemental Medical Data

DA Form 5570
Health Questionnaire for Dental Treatment (Available through normal forms supply channels.)

DA Form 5888
Family Member Deployment Screening Sheet

DA Form 5889
PEB Referral Transmittal Document

DD Form 689
Individual Sick Slip

DD Form 1966
Record of Military Processing—Armed Forces of the United States

DD Form 2005
Privacy Act Statement—Health Care Records

DD Form 2215
Reference Audiogram

DD Form 2216
Hearing Conservation Data

DD Form 2351
DOD Medical Examination Review Board (DODMERB) Report of Medical Examination

DD Form 2766
Adult Preventive and Chronic Care Flowsheet (Available through normal forms supply channels.)

DD Form 2795
Pre-Deployment Health Assessment

DD Form 2796
Post-Deployment Health Assessment (PDHA)

DD Form 2813
Department of Defense Active Duty/Reserve Forces Dental Examination

DD Form 2900
Post-Deployment Health Reassessment (PDHRA)

SF 507
Medical Record—Report on or Continuation of S.F. (Available from http://contacts.gsa.gov/webforms.nsf.)

SF 513
Medical Record—Consultation Sheet (Available from http://contacts.gsa.gov/webforms.nsf.)

SF 527
Medical Record—Group Muscle Strength, Joint R.O.M. Girth and Length Measurements

SF 600
Medical Record—Chronological Record of Medical Care

SF 603
Medical Record—Dental

SF 603A
Medical Record—Dental—Continuation

Appendix B

Management Control Evaluation Checklist

B–1. Function

The functions covered by this checklist are controls addressing medical record and health care documentation.

B–2. Purpose

The purpose of this checklist is to assist medical, administrative, and recruiting command personnel in evaluating the key management controls listed below. It is not intended to cover all controls.

B–3. Instructions

Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, other). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. Certification that this evaluation has been conducted must be accomplished on DA Form 11–2 (Internal Control Evaluation Certification). DA Form 11–2 will be locally reproduced on 81/2 by 11 inch paper. This form is available at the Army Publishing Directorate Web site (http://www.apd.army.mil).

B–4. Test questions

a. In accordance with AR 40–66, paras 1–4 and 2–2, is there a current SOP on accountability and disclosure procedures for medical records with specified individuals responsible for disclosing medical information and annual in-service and required Web-based training to educate all staff on health information privacy laws and procedures for using or disclosing protected health information?

b. In accordance with AR 40–66, para 2–5, is an accounting of all disclosures of protected health information available to patients?

c. In accordance with AR 40–66, para 5–3, are there current standing operating procedures for maintenance of health records for all Army personnel requesting actions through DA agencies?

B–5. Supersession

This checklist replaces the checklist for addressing medical record and health care documentation previously published on 18 January 2007.

B–6. Comments

Help make this a better tool for evaluating the Standards of Medical Fitness. Comments regarding this checklist should be addressed to: Headquarters, Department of the Army (HQDA), Office of the Surgeon General, DASG–HS–AS, 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Glossary

Section I

Abbreviations

AA
aeromedical adaptability

ACAP
Aeromedical Consultant Advisory Panel

ACS
Aeromedical Consultative Service

ADA
American Dental Association

ADSW
active duty for special work

ADT
active duty for training

AEDR
aviation epidemiology data register

AERO
Aeromedical Epidemiology Resource office

AFVT
Armed Force vision tester

AGR
Active Guard—Reserve

AHLTA
Armed Forces Health Longitudinal Technology Application

AHRC
Army Human Resources Command

AKO
Army Knowledge Online

AMC
Aviation medical consultant

AME
Aviation medical examiner

AMEDD
Army medical department

AMNP
Aviation medicine nurse practitioner

AMS
aero-medical summaries

AMSA
Army medical surveillance activity

ANSI
American National Standards Institute

AO
airborne operations

APA
aeromedical physician assistant

APD
Army Publishing Directorate

APFT
Army physical fitness test

APL
aeromedical policy letter

ARC
Army Reserve Command

ARMA
adaptability rating for military aeronautics

ARNG
Army National Guard

ARNGUS
Army National Guard of the United States

ASAP
Army Substance Abuse Program

ASD(HA)
Assistant Secretary of Defense (Health Affairs)

ASORTS
Army Status of Resources and Training System

AT
annual training

ATB
aeromedical technical bulletin

ATC
air traffic controller

ATP III
adult treatment panel

ATS
American Thoracic Society

AV
atrioventricular

CDQC
combat diving qualification course

CG
commanding general

CHAMP
Consortium for Health and Military Performance

CHD
coronary heart disease

CK
creatine kinase

cm
centimeter

COAD
continued on active duty

COCOM
combatant command

COMPOS
components

CONUS
continental United States

corr
corrected

CPAP
continuous positive airway pressure

CRP
c-reactive protein

CT
cover test

CV
cardiovascular

CVSP
Cardiovascular Screening Program

DA
Department of the Army

DAC
Department of the Army civilian

dB
decibels

dBA
dB measured on the A scale

DCS, G–1
Deputy Chief of Staff, G–1

DFC
dental fitness classification

DMO
diving medical officer

DMPM
Director, Military Personnel Management

DMT
diving medical technician

DNA
deoxyribonucleic acid

DNIF
duties not to include flying

DOD
Department of Defense

DODI
Department of Defense instruction

DODMERB
Department of Defense Medical Examination Review Board

DOEHRS–HC
Defense Occupational Environmental Hearing Readiness Application-Hearing Conservation

DRRS–A
Defense Readiness Reporting System-Army

DSM–IV
Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition

DVA
Department of Veterans Affairs

EEG
electroencephalogram

EKG
electrocardiogram

FAA
Federal Aviation Administration

FALANT
Farnsworth Lantern Test

FDHS
flying duty health screen

FDME
flying duty medical examination

FEB
flying evaluation board

FEDS_HEAL
Federal Strategic Health Alliance

FEVI
forced expiratory volume in 1 second

FFD
full flying duties

FMR
fully medical ready

FS
flight surgeon

FTA–ABS
fluorescent treponemal antibody absorption

FTNGD
full–time National Guard duty

GERD
gastro-esophegeal reflux disease

GXT
graded exercise stress test

HA
health assessment

HALO
high altitude low opening

HART–R
Health Assessment Review Tool

HCP
health care provider

HCT
hematocrit

HCV
hepatitis c virus

HDL
high–density lipoprotein

HE
heat exhaustion

HGB
hemoglobin

HHS
Health and Human Services

HI
heat injury

HIPAA
Health Insurance Portability and Accountability Act

HIV
human immunodeficiency virus

HPSP
Health Professions Scholarship Program

HPV
human papiloma virus

HQ
headquarters

HQDA
Headquarters, Department of the Army

HRC
Human Resources Command

HRR
health readiness record

HS
heat stroke

IBA
individual body armor

ICD
International Classification of Disease

ID
identification

IDT
inactive duty training

IFRF
individual flying records folder

IM
immunization

IMR
individual medical readiness

IMT
initial military training

IN
inch

ISO
International Organization for Standardization

JCACHO
Joint Commission on Accreditation of Healthcare Organizations

JFTR
Joint Federal Travel Regulation

LASEK
laser epithelial keratomileusis

LASIK
laser assisted in situ keratomileusis

LBE
load bearing equipment

LDL
low density lipoprotein

LOC
loss of consciousness

LOD
line of duty

m
minutes

MAAG
military assistance advisory group

MDRB
Medical Duty Review Board

MEB
medical evaluation board

MEDCEN
medical center

MEDDAC
medical department activity

MEDPROS
Medical Protection System

MEPCOM
U.S. Military Entrance Processing Command

MEPS
military entrance processing stations

METS
metabolic equivalents

MFF
military freefall

mg
milligram

mg/dl
milligrams per deciliter

MILPO
military personnel office

mm
millimeter(s)

mmHg
millimeters of mercury

MMRB
military occupational specialty medical retention board

MND
medical nondeployment module

MODS
Medical Operational Data System

MOPP
mission oriented protective posture

MOS
military occupational specialty

MPRJ
military personnel records jacket

MR
medical readiness

MRDP
Medical Retention Determination Point

MTF
military treatment facility

NATO
North Atlantic Treaty Organization

NCEP
National Cholesterol Education Program

NDAA
National Defense Authorization Act

NGB
National Guard Bureau

NGR
National Guard Regulation

NILOD
not in the line of duty

NP
nurse practitioner

NPC
near point of convergence

NSAID
non-steroidal anti-inflammatory drug

OCONUS
outside continental United States

OCS
Officer Candidate School

ODCS, G–1
Office of the Deputy Chief, G–1

OMB
Optimal Medical Treatment Benefit

OSD
Office of the Secretary of Defense

PA
physician assistant

Pap smear (test)
Papanicolaou's test

PCM
primary care manager

PCS
permanent change of station

PD
pupillary distance

PDHRA
Post Deployment Health Reassessment

PEB
physical evaluation board

PEBLO
Physical Evaluation Board liaison officer

PFP
partnership for peace

PHA
periodic health assessment

PIP
pseudoisochromatic plates

PMCS
preventive maintenance checks and services

POR
preparation of replacements for oversea movement

POS
point of service

PPPT
Pregnancy/Postpartum Physical Training

PR interval
Beginning of the P wave to the beginning of the QRS complex

PT
physical training

PTRR
Physical Training and Rehabilitation Program

PTSD
post-traumatic stress disorder

PULHES
physical, upper, lower, hearing, eyes, psychiatric

QRS complex
Represent ventricular depolarization

RAM
resident in aerospace medicine

RANDOT
random dots

RC
Reserve Component

RHRP
Reserve Health Readiness Program

RMC
Regional Medical Command

ROM
ranges of motion

ROTC
Reserve Officers' Training Corps

RPR
rapid plasma reagin (test)

RSC
Regional Support Command

RSLC
Reconnaissance and Surveillance Leaders Course

RT
right

RTO
radio/telephone operator

SCUBA
self-contained underwater breathing apparatus

SCUS
atypical squamos cells of unknown significance

SERE
survival, evasion, resistance, escape

SFAS
special forces assessment and selection

SFQC
Special Forces Qualification Course

SHA
separation health assessment

SIDPERS
Standard Installation/Division Personnel System

SODA
Statement of Demonstrated Ability

SPRINT
speech recognition in noise test

SSN
social security number

STANAG
standardized agreement

STARC
state area command

SVT
stereoscope vision testing

T
temporary (profile)

TAMP
Transitional Assistance Management Program

TBI
Traumatic Brain Injury

TOE
table of organization and equipment

TRICARE
Tri-Service Medical Care

TSG
The Surgeon General

UAS
unmanned aerial system

UASO
unmanned aerial system operators

UAVO
unmanned aerial vehicle operator

USAAMA
U.S. Army Aeromedical Activity

USAAMC
U.S. Army Aeromedical Center

USACHPPM
U.S. Army Center for Health Promotion and Preventive Medicine

USAHRC
U.S. Army Human Resources Command

USAJFKSWCS
U.S. Army John F. Kennedy Special Warfare Center and School

USAMEDCOM
U.S. Army Medical Command

USAR
U.S. Army Reserve

USAREC
U.S. Army Recruiting Command

USARIEM
U.S. Army Research Institute and Environmental Medicine

USASOC
U.S. Army Special Operations Command

USC
United States Code

USMA
U.S. Military Academy

USMEPCOM
U.S. Military Entrance Processing Command

USPSTF
U.S. Preventive Services Task Force

USR
unit status report

USUHS
Uniformed Services University of the Health Sciences

VA
Veterans Affairs

VDRL
venereal disease research laboratory

VTA
vision testing apparatus

WTRP
Warrior Training and Rehabilitation Program

WTU
Warrior Transition Unit

Section II

Terms

Accepted medical principles
Fundamental deduction consistent with medical facts and based upon the observation of a large number of cases. To constitute accepted medical principles, the deduction must be based upon the observation of a large number of cases over a significant period of time and be so reasonable and logical as to create a moral certainty that they are correct.

Applicant
A person not in a military status who applies for appointment, enlistment, or reenlistment in the USAR.

Candidate
Any individual under consideration for military status or for a military service program whether voluntary (appointment, enlistment, ROTC) or involuntary (induction).

Civilian physician
Any individual who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures in the geographical area concerned.

Deployment
The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intracontinental United States, intertheater, and intratheater movement legs, staging, and holding areas.

Enlistment
The voluntary enrollment for a specific term of service in one of the Armed Forces as contrasted with induction under the Military Selective Service Act.

Impairment of function
Any anatomic or functional loss, lessening, or weakening of the capacity of the body, or any of its parts, to perform that which is considered by accepted medical principles to be the normal activity in the body economy.

Latent impairment
Impairment of function that is not accompanied by signs and/or symptoms but is of such a nature that there is reasonable and moral certainty, according to accepted medical principles, that signs and/or symptoms will appear within a reasonable period of time or upon change of environment.

Manifest impairment
Impairment of function that is accompanied by signs and/or symptoms.

Medical capability
General ability, fitness, or efficiency (to perform military duty) based on accepted medical principles.

Obesity
Excessive accumulation of fat in the body manifested by poor muscle tone, flabbiness and folds, bulk out of proportion to body build, dyspnea and fatigue upon mild exertion, and frequently accompanied by flat feet and weakness of the legs and lower back.

Physical disability
Any manifest or latent impairment of function due to disease or injury, regardless of the degree of impairment, that reduces or precludes an individual's actual or presumed ability to perform military duty. The presence of physical disability does not necessarily require a finding of unfitness for duty. The term “physical disability” includes mental diseases other than such inherent defects as behavior disorders, personality disorders, and primary mental deficiency.

Physician
A doctor of medicine or doctor of osteopathy legally qualified to prescribe and administer all drugs and to perform all surgical procedures.

Retirement
Release from active military services because of age, length of service, disability, or other causes, in accordance with Army regulations and applicable laws with or without entitlement to receive retired pay. For purposes of this regulation, this includes both temporary and permanent disability retirement.

Sedentary duties
Tasks to which military personnel are assigned that are primarily sitting in nature, do not involve any strenuous physical efforts, and permit the individual to have relatively regular eating and sleeping habits.

Separation
An all inclusive term which is applied to personnel actions resulting from release from active duty, discharge, retirement, dropped from rolls, release from military control or personnel without a military status, death, or discharge from the ARNGUS with concurrent transfer to the Individual Ready, Standby, or Retired Reserve. Reassignments between the various categories of the U.S. Army Reserve (Selected, Ready, Standby, or Retired) are not considered as separations.

Section III

Special Abbreviations and Terms

This section contains no entries.

DX030

EXHIBIT 4

Army Regulation 600–110

Personnel-General

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus

Headquarters
Department of the Army
Washington, DC
22 April 2014

UNCLASSIFIED

SUMMARY of CHANGE

AR 600–110
Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus

This administrative revision, dated 27 June 2014--

- Modifies copy of DA Form 5669 (fig 4-1).
- Makes an administrative change to include this administrative revision (title page).

This rapid action revision, dated 22 April 2014--

- Changes Human Immunodeficiency Virus testing time requirements for Reserve Component Selected Reserve personnel from every 5 years to every 2 years (paras 3-2*k*(1), 3-2*k*(2), 7-4*a*(3), 7-4*a*(5), 7-4*b*(1), and 7-4*b*(2).
- Makes administrative changes (throughout).

Headquarters
Department of the Army
Washington, DC
22 April 2014

***Army Regulation 600–110**

Effective 22 May 2014

Personnel-General

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus

By Order of the Secretary of the Army:

RAYMOND T. ODIERNO
General, United States Army
Chief of Staff

Official:

GERALD B. O'KEEFE
Administrative Assistant to the Secretary of the Army

History. This publication is a administrative revision. The portions affected by this administrative revision are listed in the summary of change.

Summary. This regulation implements the Office of the Assistant Secretary of Defense, Health Affairs Policy Memorandum-Human Immunodeficiency Virus Interval Testing, dated March 29, 2004 and Department of Defense Instructions 6485. 01 and prescribes Army policy and responsibilities on human immunodeficiency virus testing and surveillance requirements; procedures for identification, surveillance, and administration of personnel infected with human immunodeficiency virus; testing and counseling procedures for Soldiers and other military health care beneficiaries for human immunodeficiency virus infection; requirements for testing military applicants; conditions under which civilian employees may be tested; procedures for administration of human immunodeficiency virus infected Active Army, Army National Guard/Army National Guard of the United States, and U.S. Army Reserve Soldiers; guidance on the limitations on the use of testing information; information and education requirements of the human immunodeficiency virus testing program; and guidance to law enforcement and corrections personnel in handling known or suspected human immunodeficiency virus infected personnel.

Applicability. This regulation applies to the Active Army, the Army National Guard/the Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. It also applies to candidates and applicants for accession; Department of the Army civilian employees; nonappropriated fund employees; and military health care beneficiaries. If the provisions of this regulation conflict with existing negotiated labor agreements, the terms of those agreements will be controlling until renegotiated. In any activity where a union has been granted exclusive recognition to represent civilian employees, no new conditions of employment should be implemented without prior discussion with the servicing civilian personnel officer regarding the obligation to negotiate. During mobilization, the proponent may modify chapters and policies contained in this regulation.

Proponent and exception authority. The proponent of this regulation is the Deputy Chief of Staff, G–1. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army internal control process. This regulation contains internal control provisions in accordance with AR 11–2 and identifies key internal controls that must be evaluated (see appendix B).

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from Deputy Chief of Staff, G–1 (DAPE–HR–PR), 300 Army Pentagon, Washington, DC 20310–0300.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Deputy Chief of Staff, G–1 (DAPE–HR–PR), 300 Army Pentagon, Washington, DC 20310–0300.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

*This regulation supersedes AR 600–110, dated 17 August 2012.

Contents (Listed by paragraph and page number)

Contents—Continued

Contents—Continued

Contents—Continued

DX039

Chapter 1
Introduction

Section I
General

1–1. Purpose
This regulation prescribes policy, procedures, responsibilities, and standards concerning identification, surveillance, and administration of personnel infected with human immunodeficiency virus (HIV).

1–2. References
Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

Section II
Responsibilities

1–4. Deputy Chief of Staff, G–1
The DCS, G–1 will—

a. Serve as lead agent for all HIV policies.

b. Provide Army staff supervision for the HIV program.

c. Coordinate with U.S. Military Entrance Processing Command policies pertaining to preaccession HIV testing conducted at military entrance processing stations (MEPSs).

d. Ensure that HIV policies and programs are effectively implemented consistent with Department of Defense (DOD) guidance and current medical knowledge.

1–5. The Surgeon General
The Surgeon General will—

a. Program and manage funds and resources for the support of laboratory, research, education, prevention strategies, and contractor activities for medical aspects of the overall HIV program.

b. Provide up-to-date clinical and epidemiological information to the Army staff and Secretariat on HIV and Acquired Immune Deficiency Syndrome (AIDS).

c. Develop procedures for notification and counseling of HIV infected Soldiers and other health care beneficiaries (HCBs).

d. Through the proponency office for preventive medicine, provide oversight for the identification, surveillance, and management of HIV infected Soldiers.

e. Ensure responsive laboratory support to the Active Army and reserve components (RC) and to other testing programs for authorized HCBs.

f. Advise the Office of the DCS, G–1 and the Office of the Assistant Secretary of the Army (Manpower and Reserve Affairs) of Department of the Army (DA) and DOD epidemiological information and trends.

g. Through the U.S. Army Medical Research and Materiel Command—

(1) Provide input concerning the medical administration of the HIV testing program for publication in this regulation.

(2) Provide technical oversight in support of the Army's HIV testing program, to include guidance on the most current and appropriate laboratory tests to be used for screening and confirmation.

(3) Prescribe the methodology to be used by the laboratories supporting HIV testing.

(4) Provide technical guidance for the collection and shipment of specimens.

(5) Plan, program, and manage epidemiology and research initiatives.

h. Release HIV testing statistics only in response to specific queries. Such inquiries must be processed under the provisions of the Privacy Act (Title 5, United States Code, Section 552a (5 USC 552a)) and the Freedom of Information Act (FOIA) (5 USC 552) and should be handled in accordance with the procedures of AR 25–55 and AR 340–21. Generally, HIV information about specific individuals will not be released under the FOIA, but may be released under limited circumstances pursuant to the Privacy Act or DOD 6025.18–R, Chapter 7.

i. Through the U.S. Army Public Health Command (USAPHC) formerly known as U.S. Army Center for Health Promotion and Preventive Medicine—

(1) Serve as the technical lead for the public health aspects of installation HIV programs. The USAPHC functions include program development, written program guidance, automated tools, technical assistance, local HIV program

capacity building and maintenance, and continuing education for HIV program directors/coordinators (Public Health Nurses (PHNs)).

(2) Provide central tracking for HIV infected Soldiers in order to ensure timely notification, medical evaluation, and verification.

(3) Develop commander's guidance to assist the commanders of Soldiers infected with HIV.

(4) Develop programs for health education and primary and secondary HIV prevention education for individual HCBs, especially those who are HIV infected, or at high risk.

(5) Develop community health education materials in collaboration with the Chief Nurse, USAPHC, and the public affairs community (see chap 10).

(6) Assist Army commands (ACOMs), Army service component commands (ASCCs), or direct reporting units (DRUs) in the development and implementation of community health education programs regarding HIV infection and AIDS.

1–6. Chief of Chaplains

The Chief of Chaplains will provide pastoral care by ensuring that chaplain counseling and religious support is available to Soldiers and Family members who are infected with HIV and the uninfected members of those Families.

1–7. Chief of Public Affairs

The Chief of Public Affairs will—

a. In coordination with The Surgeon General and DCS, G–1, support a command information program that informs audiences about current information pertaining to HIV infection and the AIDS epidemic.

b. Help publicize the Army's testing, research, and education efforts for prevention strategies related to HIV and AIDS.

1–8. Chief, National Guard Bureau

The Chief, NGB will—

a. Budget money and resources to provide administrative support for oversight of the HIV testing program in the Army National Guard (ARNG).

b. Provide and coordinate medical support for the notification and counseling of HIV infected ARNG Soldiers and their spouses.

c. Provide oversight and quality assurance for managing and centrally tracking HIV infected ARNG Soldiers.

d. Ensure ARNG units comply with the Army's HIV policy.

e. Advise the DCS, G–1 regarding the impact of HIV programs on ARNG personnel and units.

1–9. Commanding General, U.S. Army Human Resources Command

The CG, HRC will—

a. Function as liaison between testing sites.

b. Provide timely notification of initial HIV positive test results to the U.S. Army Reserve (USAR).

c. Provide and coordinate administrative support for the notification and counseling which is inclusive of verification blood tests and completion of annual medical evaluation which determines fitness for duty.

d. Serve as the technical lead for transfer of all confirmed HIV infected individual ready reserve (IRR) Soldiers to the USAR Standby Reserve Active.

e. Develop and implement education program for USAR Soldiers.

f. Provide oversight and quality assurance for centrally tracking career management activities of HIV infected Soldiers including nondeployable assignments, long-term schooling, request for reassignment orders, and exception to policy.

g. Serve as primary point of contact (POC) for active component (AC) issues and inquiries.

h. Code administrative records to restrict permanent change of station (PCS) movement of enrollees.

i. Coordinate and advise command, assignment, and branch management staff on program provisions.

j. Maintain data on current enrollees and reconcile data furnished by medical lab processing element.

1–10. Commanding General, U.S. Army Reserve Command

The CG, USARC will—

a. Submit to HRC money and other resource requirements to provide administrative support for oversight of the HIV testing program in the USAR.

b. Provide and coordinate medical support for the notification and counseling of HIV infected USAR Soldiers and their spouses.

c. Provide oversight and quality assurance for managing and centrally tracking HIV infected USAR Soldiers.

d. Develop and coordinate USAR HIV policy for specified and unified commands, ACOMs, ASCCs, and DRUs.

e. Advise the DCS, G–1 regarding the impact of HIV programs on USAR personnel and units.

1–11. U.S. Army Medical Command commanders

The USAMEDCOM commanders will—

a. Identify appropriate resources and locations to collect and ship specimens to the servicing laboratories.

b. Ensure that information regarding HIV test results is appropriately safeguarded according to the policies in this regulation.

c. Coordinate testing, notification, counseling, and education procedures with Office of the Surgeon General (OTSG). Provide medical support for these functions per guidance from OTSG.

d. Ensure that epidemiologic assessment interviews and counseling are performed and that all medical requirements are accomplished according to the policies in this regulation, or request exceptions to policy when appropriate.

e. Ensure that guidance published by OTSG regarding the Blood Donor and Transfusion Recipient Look Back Program is followed within their command. For more guidance see Policy on the Use of Non-U.S. Food and Drug Administration Compliant Blood Products, March 19, 2010; Blood Program Letters (BPL) 09-01, DOD Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Using Licensed Nucleic Acid Tests (NAT) With Approved Mini-Pool Strategies; and BPL 10-01, Department of Defense (DOD) Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Updated Multiplex HIV/HCV/HBV Nucleic Acid Testing Algorithm.

f. Designate the medical positions outlined in chapter 2.

1–12. Army command, Army service component command, or direct reporting unit commanders

The ACOM, ASCC, or DRU commanders will—

a. Budget money and resources to provide administrative support for oversight of the HIV testing program in their command.

b. Designate a centralized POC in their headquarters to coordinate all administrative and medical aspects and educational preventive strategies, of the HIV testing program.

c. Ensure compliance with all aspects of the HIV testing program outlined in this regulation at their various installations and activities.

d. Ensure that information regarding HIV testing results is appropriately safeguarded per the policies in this regulation.

e. Ensure that their Public Affairs Office conducts an aggressive command information program per chapter 10.

1–13. Installation and community commanders

These commanders will—

a. Coordinate with the servicing medical department activity (MEDDAC) or medical center (MEDCEN) to accomplish scheduling, education, prevention strategies, and testing of personnel assigned to or supported by their installation or community.

b. Assist servicing MEDDAC or MEDCEN in implementing HIV education programs for Soldiers, commanders, health care workers, civilian employees, and other HCBs, as needed.

c. Establish a support network of professional personnel (chaplain, psychologist, psychiatrist, social worker, and a PHN) trained to provide assistance to HIV infected Soldiers and their uninfected Family members in such areas as Family support and suicide prevention.

d. Use local assets to support command and public information efforts.

e. Consult, as appropriate, with the servicing staff judge advocate on the limited use provisions of this policy and other restrictions on the use of HIV information.

f. Ensure that military and civilian personnel receive training and education on HIV and Army policies. Soldier and health care worker HIV prevention training is coordinated by a PHN. Commanders should ensure that all nonsupervisory civilian employees are given sufficient training regarding HIV and/or AIDS in the workplace so that employees understand—

(1) The medical ramifications of HIV and/or AIDS as they relate to communicability, and as they affect an employee's ability to perform official duties; and workplace rights of employees who are HIV positive or have AIDS.

(2) Civilian employees may be excused from HIV or AIDS training in the workplace if they believe the training is offensive or may be emotionally or psychologically stressful to them. Managers and supervisors who excuse civilian employees from scheduled training will offer those employees an appropriate alternative to the training, such as written materials on HIV and/or AIDS in the workplace.

g. Ensure that information regarding HIV testing results is appropriately safeguarded per the policies in this regulation.

1–14. Unit commanders

The unit commanders will—

a. Be knowledgeable of the provisions of this regulation.

b. Ensure that HIV information and education is included in unit training programs, with emphasis on the prevention of infection. See chapter 7 for RC personnel policy.

c. Ensure that their assigned or attached personnel comply with the HIV testing requirements.

d. Accompany Soldiers identified as HIV infected to the medical treatment facility (MTF) for notification of the (first) initial positive test as soon as possible after contact by preventive medicine, and no later than 4 days after contact by preventive medicine for Soldiers on leave or not on active duty (AD) status. (Unit commanders who are general officers may designate a subordinate officer to perform this function.) Upon learning of the Soldier's HIV status, commanders will not inform the Soldier nor be present in the room during the notification or the epidemiological assessment interview.

e. Provide support and facilitate the support network for the HIV infected Soldier from the point of initial notification.

f. Protect the confidentiality of HIV infected Soldiers from unwarranted invasions of their privacy. This responsibility includes strictly limiting knowledge of a Soldier's HIV status to individuals who have a "need to know" about the medical condition in the performance of their duties as defined by the Uniform Code of Military Justice (UCMJ). Commanders and legitimate administrative, legal, and medical authorities must ensure that the recipient of the information understands his or her obligation to protect the confidentiality of that information (see para 5–4).

g. Consult, as appropriate, with the servicing staff judge advocate on the limited use provisions of this policy and other restrictions on the use of HIV test results and epidemiological information.

h. Counsel HIV infected Soldiers per the policies in section III (DA Form 4856 (Developmental Counseling Form)) following formal counseling by the installation HIV program director (DA Form 5669 (Preventive Medicine Counseling Record)), with every change of command, and within 30 days of PCS and provide a copy to the HIV program coordinator (PHN).

i. Ensure that HIV infected AD Soldiers (including Active Guard Reserve (AGR)) report, at a minimum, every 6 months for their infectious disease medical evaluation visit and comply with medical management as directed by their infectious disease physician at military MTFs that have infectious disease providers.

j. Ensure that copies of HIV infected Soldier's PCS orders are provided to the HIV PHN to communicate to the gaining HIV PHN.

Section III
Policies

1–15. General

Headquarters, Department of the Army (HQDA) medical and personnel policies on HIV reflect current knowledge of the natural progression of HIV infection, the risks to the infected individual incident to military service, the risk of transmission of the disease to non-infected personnel, the overall impact of infected personnel in Army units and on readiness posture, and the safety of military blood supplies.

1–16. Human immunodeficiency virus policies

The following are established policies on HIV:

a. HIV infected personnel are not eligible for appointment or enlistment into the Active Army, the ARNG, or the USAR (see chap 5).

b. All AD and RC personnel designated in chapters 3, 6, and 7 will be tested periodically for evidence of HIV infection. Frequency of testing will be jointly determined by the DCS, G–1 and OTSG based on available medical and epidemiological evidence.

c. All procedures involving HIV testing results will comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law (PL) 104–191) regulations and will be handled in a confidential manner to prevent unauthorized access to the information. Access will be strictly limited to individuals who have a legitimate medical, administrative, or legal need to know that information in the performance of their duties. Current HIPAA privacy and security training is required.

d. Medical follow-up and evaluation will be conducted every 6 months and as directed by the infectious disease physician for all HIV infected Soldiers (see chaps 4 and 8).

e. Except for those identified during the accession testing program (chap 5), HIV infected AD Soldiers who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations will not be involuntarily separated solely because they are HIV infected (see chaps 3, 6, and 9).

f. HIV infected AD Soldiers, including AGR, will be limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands). Soldiers identified as HIV positive while assigned outside the continental United States (OCONUS) will be reassigned to the United States per AR 614–30, and this regulation.

Direct coordination with Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303; Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450 (for ARNG AGR Title 10 personnel); or Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303 (for USAR AGR personnel), will be made to ensure expeditious reassignment of HIV infected Soldiers (see chap 6).

(1) The duty limitation discussed above does not apply to RC personnel who reside overseas, or to AD Soldiers who are permanent residents of, and are currently stationed in Guam, the Virgin Islands, or American Samoa. It does, however, apply to all AD Soldiers not currently assigned to these locations, regardless of permanent residence.

(2) HIV infected Soldiers outside these areas who desire compassionate reassignment to these areas may apply per existing policy for compassionate reassignments. Requests will be considered on a case-by-case basis.

g. Conditions of national emergency and/or mobilization and deployment overseas may require reordering of priorities for screening and assignment of HIV infected Soldiers, but will not affect overseas assignment limitations. The Personnel Policy Guidance will contain HIV policy for particular wars, conflicts, or mobilization situations.

h. Unless modified by a combatant command (COCOM), AD Soldiers are considered available for deployment if they have a negative serum screening collected within 1 year of deployment.

i. RC Soldiers are considered deployable if they have a negative HIV test recorded within 5 years of scheduled deployment (or date of unit status report). However, upon mobilization, all Soldiers being ordered or called to AD will be tested for HIV within 24 hours of reporting to their mobilization station if there is no record of a negative HIV test within the previous 24 months.

j. Initial screening HIV test results will normally be available within 48 hours, but may be delayed due to logistical limitations. Soldiers will not be deployed until test results are known. If the test results are negative, the Soldier is considered available for deployment. If the initial test results are positive, the Soldier will be removed from further processing until independent verification tests are conducted and results are known.

k. HIV infected Soldiers who demonstrate rapidly progressive clinical illness or immunological deficiency may not meet medical retention standards under AR 40–501, and will be evaluated for physical disability processing under AR 635–40. (See paras 6–13 for officers and 6–14 for enlisted personnel.)

l. It is essential that HIV infected Soldiers provide accurate information during the epidemiological assessment process conducted confidentially by the HIV program director or coordinator (PHN). Accordingly, the mere presence of the HIV antibody or other medical evidence of HIV infection alone will not be used as the basis for adverse action against a Soldier (see chap 9).

m. Soldiers found to be HIV infected will have HIV listed on the medical problem list. As part of the commander's counseling, they will be counseled and ordered not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs due to the risk of HIV transmission to recipients (see chap 4).

n. Mandatory testing of civilians (to include Family members) is not authorized, with the exception of those specific situations that may be defined and approved by DOD. Those situations will be published by HQDA (DAPE–CP or DAPE–HR) as they occur. Voluntary testing will be made available to all HCBs and civilian health care providers per chapter 8.

o. Except as stated below, civilian employees who have been diagnosed with HIV or AIDS must be permitted to continue to work so long as their performance is acceptable and they do not pose a significant risk of substantial harm to the health or safety of themselves or others that cannot be eliminated or reduced by reasonable accommodation. If serious performance or safety problems arise, managers and supervisors should address them by applying existing Federal and Army civilian personnel policies and practices. Further guidance is available in chapter 8.

p. There is no basis for civilian employees to refuse to work with fellow employees, Soldiers, or agency clients who have, or are suspected of having HIV or AIDS. The concerns of such employees will be addressed with education and counseling as appropriate. If an employee's continued refusal to work with a person with HIV or AIDS results in disruption in the workplace, appropriate disciplinary action may be taken against the employee. Further guidance is available in chapter 8.

q. Civilian employees with HIV or AIDS usually are considered "individuals with disabilities" within the meaning of the Rehabilitation Act of 1973, as amended (29 USC 701), the Americans with Disabilities Act (ADA) of 1990, as amended (42 USC 12101), and the Americans with Disabilities Act Amendments Act (ADAAA) PL 110–325), and, if otherwise qualified, are entitled to reasonable accommodation.

r. News media inquiries concerning HIV and/or AIDS policies, testing, or issues will be handled as follows:

(1) Routine news media queries on a local level will be directed to the appropriate Public Affairs Office. Media queries concerning Army HIV and/or AIDS policies should be referred to the Office of the Chief of Public Affairs, Media Relations Division.

(2) HIV testing statistics will be released only in response to specific queries. Such inquiries must be processed under the provisions of the Privacy Act (5 USC 552a) and the FOIA (5 USC 552) and should be handled in accordance with the procedures of AR 25–55 and AR 340–21. Generally, HIV information about specific individuals will not be released under the FOIA, but may be released under limited circumstances pursuant to the Privacy Act and DOD 6025.

18–R. In order to prevent accidental disclosure of HIV information that may be attributable to specific individuals, statistics may only be released for major installations or major commands.

s. Policies contained in this regulation will be reviewed as developments occur in scientific and/or medical knowledge, or issuances of revised DOD policies dictates.

Chapter 2
Installation Level Human Immunodeficiency Virus Program Management

2–1. General

a. The HIV program elements include the following:

(1) Prevention and education.

(2) Initial and verification HIV testing.

(3) Patient notification.

(4) Counseling.

(5) Contact tracing.

(6) Reporting.

(7) Medical evaluation and management.

(8) Profiling, fitness for duty evaluations, and medical boards.

(9) Medical record keeping.

(10) Personnel actions.

(11) Case management.

(12) Program oversight and quality assurance.

(13) Training and education.

b. The MTF commanders will assign appropriately trained individuals to the roles outlined in paragraph 2–2. Because of variations in medical staffing levels and expertise at different installations, MTF commanders may organize the local program as appropriate and within the general guidelines.

2–2. Human immunodeficiency virus program medical personnel

The functions delineated below may be reallocated with concurrence of USAMEDCOM commanders specified in paragraph 1–11.

a. Installation human immunodeficiency virus program director. This is a preventive medicine physician or other physician designated by the deputy commander for clinical services. The installation HIV program director—

(1) Monitors and ensures implementation of the program as outlined in this regulation.

(2) Supervises the installation HIV PHN.

(3) Serves as POC to the MTF laboratory for HIV testing and shall be the ordering provider for the routine HIV tests (medical readiness force testing, physical exams).

(4) Notifies the Soldier, in a face-to-face encounter, of a positive HIV test result in the absence of the provider ordering the test for clinical reasons, obtains a (second) verification test, and initiates referral to the servicing MEDCEN infectious disease service.

(5) Completes the initial DA Form 5669.

b. Installation human immunodeficiency virus program coordinator (PHN or designee). The PHN—

(1) Receives results from the clinical laboratory manager identifying new HIV infections.

(a) AD Soldiers are managed by the HIV program coordinator (PHN).

(b) Reserve and Guard Soldiers are referred to the appropriate Reserve or Guard HIV POC.

(c) AGR Soldiers are referred to the appropriate Reserve or Guard HIV POC and jointly managed with active HIV PHN.

(d) AD Navy, Marine Corps, Coast Guard, and Air Force Servicemembers are referred to the appropriate Service HIV POC.

(e) Retirees and Family members are referred to the servicing MEDCEN infectious disease service after a face-to-face notification of the initial and verification HIV positive test results. The notification procedures are the same as an AD Servicemember except commanders are not informed. The confidential epidemiological assessment is completed by the HIV PHN or referred to local public health officials.

(2) Informs the ordering provider of a new positive HIV test result if performed for clinical reasons, and the need for a face-to-face notification, second verification test, and referral to the servicing MEDCEN infectious disease service. If the test was performed for routine screening (medical readiness force testing, physical exam), inform the HIV program director.

(3) Confirms the identities of the commander and the Soldier with two unique identifiers before the commander is notified of the positive test result.

(4) Provides training on this regulation for the commander before initial commander's counseling.

(5) Coordinates notification of the Soldier, in a face-to-face encounter, of new positive HIV test result by the ordering provider or HIV program director, and obtains a second verification test.

(6) Coordinates the DA Form 5669 after notification of the (first) positive HIV test.

(7) Coordinates completion of the commander's counseling (DA Form 4856) on the same day and immediately following the DA Form 5669 counseling.

(8) Contacts installation HRC HIV POC and central AC or RC HRC HIV POC for assignment-limiting actions.

Note. For Reserve and Guard assignment-limiting actions see chap 7.

Sends memorandum with following information to central AC or RC HRC HIV POC by encrypted email or confidential fax:

(a) Subject: Medically Nondeployable.

(b) Reference: AR 40–501, Standards of Medical Fitness.

(c) Statement: For Official Use Only (FOUO) in accordance with the above reference, (person's rank, name, and last four digits of the social security number) is assessed as medically nondeployable effective (date of the first positive HIV test).

(d) Statement: Further information is available upon request. POC is (name, phone, and DOD email address of the HIV PHN).

(e) Signature block: HIV program director.

(9) Coordinates appointments for the initial medical evaluation with the servicing MEDCEN infectious disease service after notification of the (first) positive test.

(10) Coordinates a psychosocial evaluation and behavioral health appointment(s) following the initial notification or during the first infectious disease clinic medical evaluation visit and, as needed, for depression screening and suicide prevention.

(11) Provides HIV counseling and education, including community resources.

(12) Assesses for latent tuberculosis infection and counsels those who have opted out of latent tuberculosis infection treatment in the past to reconsider given their increased risk of active disease.

(13) Conducts initial confidential epidemiological assessment for the period from 3 months prior to last negative HIV test or 12 months in absence of a prior test to notification of the first positive test, and completes contact interview(s) in accordance with the Centers for Disease Control and Prevention (CDC) guidelines. Additional epidemiology assessment may be needed for public health purposes.

(14) Completes Federal, State, local, or host nation public health reporting.

(15) Locates, notifies, and counsels all military HCBs named as contacts of the HIV infected Soldier. If named contacts reside outside the catchment area, contacts the appropriate military HIV program coordinator (PHN) or other appropriate public health officials for notification and testing of contacts.

(16) Reviews Soldier responsibilities as reflected in the preventive medicine counseling (DA Form 5669) and commander's counseling (DA Form 4856) statements.

(17) Completes DA Form 7303 (Donor/Recipient History Interview) during the contact interview and submits to the local Army Blood Donor Center or, if there is no donor center on the installation, submits the completed form to the MTF's laboratory manager who, in turn, will submit it to the Army Blood Program Office (see fig 2–1 for a sample of completed DA Form 7303).

(18) Assures HIV infected Soldier's Medical Protection System (MEDPROS) documentation reflects a profile deployment restriction code (V) and medical nondeployment module "Yes" following notification of the confirmatory test from the first specimen. Coordinates periodic health assessment (PHA) at diagnosis and annually for AC, as required.

(19) Maintains, in a locked cabinet, a registry of all known HIV infected Soldiers within the catchment area per OTSG preventive medicine policy and in accordance with HIPAA, and maintains a duplicate file that includes DA Forms 5669, 4856, and 7303, public health forms, and demographic data. DA Forms 5669 and 4856 will not be scanned into the electronic medical record. Upon PCS the duplicate file contents are sent to the gaining HIV program coordinator (PHN). Upon the expiration term of service or retirement, the duplicate file will be destroyed.

(20) Meets with the HIV infected Soldier annually to complete a new DA Form 5669, update demographics, review safer sex counseling, and coordinate medical readiness. If the Soldier has not completed a medical evaluation every 6 months with the infectious disease physician he or she is out of compliance with this regulation, prompting commander notification.

(21) Coordinates Soldier transfer out of catchment area within 30 days of PCS to a new duty station and sends preventive medicine and commander's counseling statements encrypted or by confidential fax to gaining HIV program coordinator (PHN).

(22) Receives Soldier transfer into catchment area within 30 days of Soldier PCS, reviews Soldier responsibilities,

updates the preventive medicine counseling, coordinates commander's counseling, provides infectious disease clinic appointment information, coordinates medical readiness PHA, completes local health department reporting, and provides community resources.

(23) Coordinates HIV education programs for health care workers and unit-level training, as requested.

(24) Reviews HIV test results with MTF or MEDCEN laboratory HIV POC daily to weekly if not performed by the HIV program director.

c. Notifying individual. This is the ordering provider in a face-to-face appointment. For all other situations, this is a preventive medicine physician or other trained health care provider (skill level 2 or licensed independent provider). The notifying individual—

(1) Completes a psychosocial assessment and, as needed, referral to behavioral health.

(2) For Army medical and infectious disease staff, informs the MTF preventive medicine HIV director or coordinator (PHN) of AD Navy, Marine Corps, Coast Guard, and Air Force Servicemembers with a suspected or confirmed HIV infection.

d. Medical evaluation. This is completed by the regional MEDCEN infectious disease clinic after positive HIV verification. Initial appointments are scheduled by the HIV PHN. This includes—

(1) Conduction a medical reevaluation every 6 months and as directed by the infectious disease physician.

(2) Documenting safer sex education and nondeployable status in medical assessments.

(3) Ensuring HIV PHN is aware of known HIV positive Soldiers and beneficiaries, to include knowledge of impending PCS.

(4) Advising UCMJ commander of noncompliance with medical management of HIV infection pursuant to involuntary separation (see paras 6–13 and 6–14).

e. Psychosocial evaluation. This is completed by behavioral health or infectious disease clinic social work or psychiatry staff. This includes—

(1) Documenting evaluation in the electronic medical record.

(2) For communities with limited resources, pastoral care and chaplains providing support until medical evaluation appointments at the regional MEDCEN.

f. Clinical laboratory manager or blood bank officer. This function will—

(1) Coordinate obtaining unit-level and individual blood specimens for testing required by this regulation and other references.

(2) Maintain data concerning force testing and clinical screening, including the number of specimens drawn, the number submitted, results of initial testing, and results of confirmatory testing.

(3) Ensure compliance with guidelines for obtaining, processing, labeling, packaging, shipping, and storing specimens.

(4) Serve as local POC for matters pertaining to contracted laboratory support.

(5) Initiate look back investigation on any previous blood donations.

DONOR/RECIPIENT HISTORY INTERVIEW

For use of this form, see AR 600-110; the proponent agency is the DCS, G-1.

DATA REQUIRED BY THE PRIVACY ACT OF 1974.

AUTHORITY:	Title 5, United States Code *(USC)*, Section 301; Title 44, USC, Section 3101; and Title 10 USC. Section 1071.
PRINCIPAL PURPOSE:	To collect information from confirmed HIV infected individuals who indicate a past history of donating or receiving blood, blood products, organ *(s)*, tissue or sperm since 1977.
ROUTINE USES:	Information collected may be released to appropriate medical authorities in order to properly investigate the final disposition of any donations or recipient events recorded on this form.
DISCLOSURE:	Disclosure of information requested is voluntary. However, failure to provide the required information may hinder lookback procedures.

1. NAME OF INDIVIDUAL *(Last, First, Middle Initial)*: Doe, John Q.

2. CURRENT ADDRESS *(Number, Street, City, State)*: 111 First Street, Ft. Knox, KY 40121

3. SOCIAL SECURITY NUMBER: 000-00-0000

4. TELEPHONE NUMBER *(Include area code)*: WORK: (111) 000-0000 HOME: (000) 111-1111

5. DATE OF BIRTH (Mo. Day, Yr): 19890101

6. SEX: ☐ Male ☒ Female

7. I acknowledge that it may be necessary to release information to my confirmed HIV status by representatives of the Medical Advisory Committee of Any Army Community Hospital *(Medical Treatment Facility)* to the appropriate medical authorities in order to properly investigate the final disposition of any donations or recipient events recorded below. I hereby give permission for the release of this information.

John Q. Doe (signed) *(Signature)* — 20120505 *(Date)*

Jane Smith *WITNESS (Print/Type Name)* — Jane Smith (signed) *(Signature)* — 20120505 *(Date)*

COL John Q. Smith *Medical Advisory, Point of Contact: (Name)* — (111) 111-0000 *Telephone Number (DSN)* — (111) 111-0000 *(Commercial)*

8. Military Beneficiary Status *(Please Check appropriate category)*:

Active ☒ Dependent of Active Duty ☐ Sponsor's Name ____

Retired ☐ Dependent of Retired ☐ Sponsor's SSAN ____

Civilian ☐ Service Army ☐ Navy ☐

Air Force ☐ Marine ☐ Other ☐ *(Identify)* ____

9. Have you donated any blood, blood product, organ *(s)*, tissue or sperm since 1977? *(Please check appropriate response.)*

YES ☒ NO ☐

10. If the answer to question #9 is YES, please indicate below the type and number of times you have donated. *(Please circle appropriate response and indicate the number of times below.)*

Blood / Blood Products Number Blood/2

Organ (s) / Tissues Number ____

Sperm Number ____

11. For each donation indicated above please provide that date and location below. Please note that any and all documentation pertaining to the donation events indicated above should be utilized to ensure that accurate information is provided. If exact information concerning the locations or dates is not available,then please provide the information that is available.

Donation #1 Type Blood *Date (Month, Day, Yr)* 20070110

Name or Organization Any Army Community Hospital

Location Ft. Knox, KY 40121 *(Street Address, City, State, Zip Code)*

Donation #2 Type Blood Date *(Month, Day, Yr)* 20101022

Name or Organization Any Army Community Hospital

Location Ft. Knox, KY 40121 *(Street Address, City, State, Zip Code)*

DA FORM 7303, JAN 1994 APD LF v1.01

Figure 2–1. Sample of completed DA Form 7303

Donation date and location continues. *(Please use additional sheets, if necessary.)*

Donation #3 Type _____ Date *(Month, Day, Yr)* _____

Name or Organization _____

Location _____

(Street Address, City, State, Zip Code)

12. Have you been the recipient of any blood, blood product, organ *(s)* , tissue or sperm since 1977? *(Please check appropriate response.)*

YES ☒ NO ☐

13. If the answer to question #12 is YES, please indicate below the type and number of times you have been a recipient. *(Please circle appropriate response and indicate the number of times below.)*

Blood / Blood Products Products Number 1

Organ (s) / Tissues Number _____

Sperm Number _____

14. For each receipt indicated above please provide that date and location below. Please note that any and all documentation pertaining to the donation events indicated above should be utilized to ensure that accurate information is provided. If exact information concerning the locations or dates is not available, then please provide the information that is available. *(Please use additional sheets, if necessary.)*

Receipt #1 Type Blood Date *(Month, Day, Yr)* June 9, 1977

Name or Organization Ft. Knox, KY 40121

Location Any Army Community Hospital

(Street Address, City, State, Zip Code)

Receipt #2 Type _____ Date *(Month, Day, Yr)* _____

Name or Organization _____

Location _____

(Street Address, City, State, Zip Code)

Receipt #3 Type _____ Date *(Month, Day, Yr)* _____

Name or Organization _____

Location _____

(Street Address, City, State, Zip Code)

15. REMARKS

REVERSE OF DA FORM 7303, JAN 1994 APD LF v1.01

Figure 2–1. Sample of completed DA Form 7303–Continued

Chapter 3
Human Immunodeficiency Virus Testing

Section I
Introduction

3–1. General

a. Soldiers may not refuse mandatory HIV testing of the force, and will be informed of the pending procedure and referred to the HIV PHN for current CDC written patient education and counseling, as needed.

b. A testing, counseling, and surveillance program for HIV infection is necessary to—

(1) Assist in ensuring the continued readiness and deployability of the total force.

(2) Preserve the health of DA personnel and their Families by identifying HIV infected HCBs and providing appropriate counseling and medical treatment.

(3) Determine fitness for military duty.

(4) Permit commanders to assess the readiness, security, military fitness, good order, and discipline of their commands, and to take appropriate action based upon such assessment.

(5) Avoid potential complications of, and adverse reactions to, immunizations among HIV infected individuals, particularly new accessions to AD Army.

(6) Develop scientifically based information on the natural history and transmission pattern of HIV.

3–2. Testing categories

HIV testing will be performed in the following situations:

a. Accessions testing. See chapter 5.

b. Active force surveillance testing. See chapter 6.

c. Army National Guard and United States Army Reserve surveillance testing. See chapter 7.

d. Blood donor testing. All military blood donors will be screened for HIV using industry standards, ensuring compliance with Food and Drug Administration (FDA) requirements. AD HIV infected Soldiers will be referred to the HIV PHN. HIV infected Soldiers (both AD and RC) identified during civilian blood drives on military installations will be reported to the HIV PHN.

e. Clinical indications. All AD Soldiers with signs and/or symptoms compatible with or suggesting HIV infection, such as lymphadenopathy (enlarged lymph nodes), unexplained lymphopenia or leukopenia (depressed white cell count), thrombocytopenia (depressed platelet count), neurological disease, adult oral candidiasis (thrush), or evidence of opportunistic infections (such as pneumocystis pneumonia, candida esophagitis, or mononucleosis syndrome), will be tested in either the outpatient or inpatient setting as part of the medical evaluation.

f. Patients with sexually transmitted infections. These patients are seen mainly in primary care, sexually transmitted disease (STD), obstetrics and gynecology, urology, or dermatology clinics, but also may be seen in any MTF clinic or ward. Per CDC STD treatment guidelines, HIV testing is indicated with each new infection to include chlamydia, gonorrhea, nonspecific urethritis, syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, genital herpes, hepatitis, or other sexually transmitted infections (STIs). Such procedures are necessary to detect seroconversion in latent infections. HIV testing of AD Soldiers with a new STI is mandatory, and is the responsibility of the provider who ordered the initial test or made the clinical diagnosis. Patients found to be HIV infected will be evaluated per paragraph 4–11.

g. Blood transfusion or blood product recipients. The policies of the Armed Services Blood Program and guidelines of the FDA will be followed in the DA Blood Program and by civilian blood agencies collecting blood on Army installations.

(1) Blood or blood product donors whose donation tests positive for HIV will be notified, counseled, and evaluated, as required by this regulation.

(2) Recipients of blood products obtained from donors who are later determined to be HIV infected will be located, notified of the potential risk, and tested and evaluated.

(3) Donors of blood or blood products whose donations were transfused to recipients who were later determined to be HIV infected will be located, notified of their potential infection, and tested.

h. Sexual partners.

(1) Soldiers and other HCBs who are, or have been, sexual partners of HIV infected individuals will be tested. Although there are no documented cases of casual nonsexual transmission of infection, Soldiers who are household members with HIV infected individuals and are not sexual partners will be offered testing if there is any anxiety over the potential for household or casual nonsexual transmission.

(2) RC medical authorities will report information pertaining to HIV infected RC Soldiers and their identified sexual partners, including spouses, through designated channels to the RC HIV PHN or designee. That information will, in turn, be provided to State or local jurisdiction public health authorities in accordance with laws or reporting requirements. Specific guidance for reporting is included in detailed implementing instructions published by the NGB or Office of the Chief, Army Reserve (OCAR).

i. Intravenous drug use. Soldiers known to have used drugs intravenously will be routinely screened for HIV.

j. Voluntary screening. Individuals who engage in high risk behavior, such as having sex with known HIV infected persons or having multiple sexual partners, will be encouraged to be tested. HIV counseling and testing is available from the preventive medicine department PHN for any Servicemember or eligible beneficiary. See chapter 7 for Army RC personnel policies and procedures.

k. Overseas assignments. Unless modified by a COCOM, host nation, or other policy that requires earlier testing, personnel who are awaiting a PCS overseas or are scheduled for overseas deployments or temporary duty (TDY) must be screened and receive a negative HIV test result if they have not been tested within the 6 months preceding their departure. Individuals alerted for overseas assignments will be instructed, as part of their Soldier reassignment processing requirements, to report to the appropriate physical examination clinic or laboratory for a blood sample. For routine HIV testing requirements see paragraph 6–2 for Active Army and paragraphs 7–2 and 7–5 for ARNG and USAR. The following policy applies unless COCOM or host nation's policies require earlier testing:

(1) RC Personnel called to AD or scheduled for overseas deployments or TDY assignment require a negative HIV test within 2 years of the date they are called to AD regardless of whether the duty is overseas or in the United States (unless the host nation's policies require testing closer in time to arrival in the host nation).

(2) RC personnel located outside the United States scheduled for training either in the United States or overseas who do not meet the testing windows stated above will be tested immediately upon arrival at the training duty station when testing prior to departure is impractical.

l. Restricted assignments. Soldiers on orders for assignment to one of the units or programs identified in paragraph 6–3*b* must be screened and test negative for HIV infection if they have not been tested within the previous 6 months in accordance with AR 614–30. Individuals alerted for these assignments will be instructed to report to the appropriate physical examination clinic or laboratory for drawing of blood. Soldiers testing positive for HIV will not be assigned to a restricted unit or program.

Section II
Human Immunodeficiency Virus Testing Procedures

3–3. General human immunodeficiency virus testing procedures

HIV testing will include screening of all personnel designated in this regulation and verification of those who test positive by initial HIV screening tests.

a. The screening and verification for HIV will be an FDA-approved test and will be in accordance with Public Health Service or CDC guidelines.

b. Testing will be as follows, but may be modified by USAMEDCOM to reflect current best practice:

(1) Initial testing (first specimen).

(a) Personnel will receive an initial screening test performed by a designated facility in accordance with paragraphs 3–4 and 5–3.

(b) If the initial screen is HIV nonreactive, the Soldier is negative for HIV.

(c) If the initial screen is HIV reactive, the specimen will be retested in duplicate to ensure accuracy.

(d) If either of the duplicate tests is reactive, the specimen will be forwarded for confirmatory testing.

(2) Confirmatory testing (first specimen).

(a) If the specimen is repeatedly reactive (two of three tests are reactive), the specimen will reflex to supplemental confirmatory testing using a comparable FDA-approved antibody or nucleic acid test.

(b) If the confirmatory test fails to detect HIV antibody, antigen, and/or nucleic acid then the specimen is considered negative.

(c) If the confirmatory test detects either HIV antibody, antigen, and/or nucleic acid, then a second independent verification specimen will be collected from the individual as soon as possible and sent for identical testing.

(d) If the confirmatory test is indeterminate (detection of antibodies significant in the detection of HIV, but not confirmatory), the sample will be reflexed to qualitative nucleic acid testing for resolution of infection status.

(3) Second independent verification specimen (second specimen).

(a) If the second independent verification specimen result is concordant with the initial positive result, the individual will be medically evaluated for HIV infection at a designated Army MEDCEN.

(b) If the second independent verification specimen result is discordant with the initial positive, then a third specimen will be collected for definitive HIV testing and coordinated through the USAMEDCOM designated laboratory.

(4) Definitive HIV testing (third specimen).

(a) The USAMEDCOM designated laboratory will use the most current, FDA-approved laboratory techniques available for detection of HIV antibody and viral nucleic acid.

(b) If positive, the individual will be medically evaluated for HIV infection at a designated Army MEDCEN.

(c) If negative, the individual is not infected.

3–4. Medical and laboratory support for testing

a. Blood drawing and initial processing of samples from AD Soldiers being tested under the force surveillance program, RC personnel upon prior arrangement, or patients participating in routine adjunct testing will be accomplished by existing medical resources, under the direction of the clinical laboratory manager or other qualified official.

(1) USAMEDCOM will provide and/or coordinate necessary resources for testing support in the United States (including Alaska and Hawaii).

(2) In Europe, the Landstuhl Army Regional Medical Center, under guidance of USAMEDCOM and OTSG, will support all Army personnel in the European Command and Central Command by coordinating collection, processing, and shipment of specimens to USAMEDCOM identified testing facilities.

(3) Army personnel stationed in Korea, Japan, and the Pacific area will be supported as in paragraph (2), above by Tripler Army Medical Center, under guidance of USAMEDCOM and OTSG.

(4) Army personnel in Central and South America will be supported by the Southern Regional Medical Command, under guidance of USAMEDCOM and OTSG.

b. Civilian contract support will be used as discussed below.

(1) Central contracting for HIV screening and verification is the responsibility of OTSG, with support from USAMEDCOM and the U.S. Army Medical Research and Materiel Command.

(2) Contract testing may be used for accession, force surveillance, and routine adjunct testing.

(3) For RC surveillance testing, contracts will require the contractor to perform transportation and testing of blood.

(4) HIV screening capability may be maintained at MTFs to meet in-house requirements for patient HIV testing in time-sensitive patient care activities. These in-house testing procedures may be used to establish suspicion of infection, but screening, verification, and follow-up testing will be performed at USAMEDCOM designated laboratories.

(5) HIV screening or verification tests by other than USAMEDCOM designated laboratory or contract sources are not acceptable to meet any testing requirement established in this regulation.

Chapter 4
Notification, Counseling, Clinical Care, and Medical Records

Section I
Introduction

4–1. General

a. Patient notification, counseling, verification, contact tracing, clinical evaluations, and personnel actions will be completed as rapidly and professionally as possible. HIV PHN will be integral to the coordination and tracking of all aspects of this process.

b. Directors of health services, MEDDAC/MEDCEN commanders, command surgeons, unit surgeons, and clinic commanders will coordinate efforts in notifying individuals, commanders, and units.

4–2. Sensitive information

Information on HIV infected Soldiers will be handled in a sensitive manner and will comply with HIPAA standards.

Section II
Notification Procedures

4–3. Laboratory and provider notification

a. At USAMEDCOM, the HIV testing contractor or USAMEDCOM designated laboratory will notify the laboratory officer or POC designated at each MTF of the identity (by two unique identifiers, one of which must be the assigned laboratory specimen number) of specimens that test positive or negative for HIV by FDA-approved test (see chap 7 for USAR policy).

b. As an adjunct to routine laboratory notification of the ordering physician, the installation HIV PHN will regularly review new HIV test results with the MTF laboratory, preferably each work day. The HIV PHN will contact the ordering provider as soon as a positive test is identified.

4–4. Notification of the Soldier's Uniform Code of Military Justice commander

a. The HIV PHN will contact the commander in person or by telephone. The identities of the commander and the Soldier will be confirmed with two unique identifiers before the commander is notified of the positive test result. This should occur as soon as possible after receiving the results from the first positive sample, but no longer than 4 days after receipt of results for Soldiers on leave or not on AD status.

b. The HIV PHN will instruct the commander not to notify the Soldier about the test result. The HIV PHN will review commander's responsibilities in paragraph 1–14.

c. The commander will accompany the Soldier to the MTF, but will not be present in the room when the Soldier is notified about the (first) initial positive test by the medical provider.

d. The commander will accompany the Soldier to the MTF, but will not be present in the room when the Soldier is notified about the (second) positive verification test by the medical provider.

e. The commander will complete DA Form 4856 immediately after completion of DA Form 5669 (fig 4–1) (completed by the HIV program director) and provide a copy to the HIV PHN and Soldier. The HIV PHN will serve as a resource for the commander.

4–5. Soldier notification

a. All Soldiers will be individually and privately notified of all positive HIV test results in a face-to-face interview with the ordering provider or HIV program director.

b. After the first positive sample—

(1) The face-to-face notification must occur as soon as possible after the commander is contacted by preventive medicine and no later than 4 days after contact by preventive medicine for Soldiers on leave or not on AD status.

(2) The Soldier will be informed that he or she has a positive western blot or other FDA-approved test, which indicates HIV infection, and that a second blood sample will be drawn and sent for second independent verification.

(3) The Soldier will be advised not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs and to refrain from sex until evaluated by the MEDCEN infectious disease service. The ordering provider will ensure the Soldier is informed that continuing to have sex without CDC recommended condoms or barriers may place sexual partners at risk of infection.

(4) The Soldier will be advised to immediately notify his or her spouse and/or sexual partner(s) of his or her infection. The Soldier will be advised that the HIV program director or coordinator (PHN) will verify that the spouse was informed and offer counseling and testing services.

(5) The Soldier will be asked if he or she has ever donated blood, and a DA Form 7303 (fig 2–1) will be completed on every Soldier, regardless of donation history, by the HIV PHN and forwarded to the Army Blood Program.

(6) The Solder will be assessed for the need of an immediate evaluation by behavioral health.

(7) The Soldier will be referred to the regional MEDCEN infectious disease service after the first positive western blot or other FDA-approved test which indicates HIV infection.

(8) The HIV program director will complete DA Form 5669 (fig 4–1) after notification of the first positive test and provide the original to the commander and copies to the Soldier and the HIV PHN.

(9) The UCMJ commander will complete DA Form 4856 after completion of DA Form 5669 and provide copies to the Soldier and the HIV PHN.

4–6. Notification of contacts of human immunodeficiency virus infected personnel

a. The HIV PHN will locate, notify, and counsel all military HCBs named as contacts to the HIV infected Soldier. The HIV PHN will verify the spouse of the newly infected Soldier was informed. If named contacts reside outside the catchment area, contact the appropriate military HIV PHN or other appropriate public health officials for notification and testing of contacts.

b. Information should be reported to civilian public health authorities, per local jurisdiction reporting requirements, when information is obtained through the epidemiological assessment interview indicating individuals who—

(1) Are not military personnel or military HCBs who are/were sexual partners of known HIV infected individuals.

(2) Were transfusion or blood product recipients from HIV infected donors.

4–7. Notification of the U.S. Army Human Resources Command

a. The Armed Forces Health Surveillance Center, designated central HIV program official, and the local HIV PHN will notify the officer and enlisted HIV POCs at HRC (AC or USAR HIV POC, as appropriate) after the first positive sample (see para 2–2*b*(8)).

b. HRC will place a formal nondeployable flag on the Soldier's record after the first positive sample. This will help ensure completion of the second independent verification test and will help prevent HIV infected Soldiers from deploying. The flag will be removed if the second and/or third independent verification tests are negative.

Section III
Counseling Procedures

4–8. Preventive medicine counseling

After the Soldier is notified about the first HIV positive test result (see para 4–5), the HIV program director will verbally counsel the Soldier on the relationship between HIV, the blood tests, and AIDS; the risks of disease transmission to close personal contacts and Family members; methods of prevention; and the fact that HIV infected individuals are not eligible to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, and organs. Verbal preventive medicine counseling will occur after the first positive HIV test. The initial counseling will be recorded using DA Form 5669 (fig 4–1). Copies will be given to the Soldier and his or her commander.

4–9. Commander's counseling

a. Commanders will formally counsel Soldiers face-to-face after notification of their (first) positive HIV test and completion of the DA Form 5669. For AD and RC personnel, command counseling will be performed after the preventive medicine counseling. Commanders will use DA Form 4856, maintain the completed counseling forms in a locked filing cabinet or other storage unit to protect the confidentiality of the information, and provide a copy to the HIV PHN.

(1) When the commander counsels the HIV exposed Soldier, the following should be entered verbatim on DA Form 4856 in part III—Summary of Counseling (see http://www.armyg1.army.mil/hr/hivdna/ref_hiv.asp for a word document of the content):

I have been advised that you were counseled by the preventive medicine personnel concerning your positive HIV test, the risk HIV infection poses to your health, and the potential for transmitting HIV to others. You were advised by the preventive medicine personnel of the necessary precautions you must take to minimize the health risk to others as a result of your HIV infection. While I have great concern for your situation, in my capacity as your commander I must also be concerned with, and ensure the health, welfare, and morale of the other Soldiers in my command. Therefore, I am imposing the following restrictions:

(a) You will verbally advise all prospective sexual partners of your HIV infection prior to engaging in any sexual activity. You are ordered to use condoms should you engage in oral, vaginal, penile, or anal sexual activity with a partner.

(b) You will not donate blood/blood products, sperm/semen or eggs, breast milk, tissues, and organs, and will report previous donations to the HIV PHN.

(c) You will notify medical, dental, and emergency health care workers of your HIV infection.

(d) You will comply with the medical management of HIV infection directed by your infectious disease physician, to include medical evaluations every 6 months and as needed.

(e) You are nondeployable and may not go TDY OCONUS.

(f) You will obtain a PHA facilitated by the HIV PHN as soon as possible and annually.

(g) You will out-process and in-process with your preventive medicine HIV PHN as part of every PCS move.

(2) The following should be entered verbatim on DA Form 4856 in part III—Plan of Action (see http://www.armyg1.army.mil/hr/hivdna/ref_hiv.asp for a word document of the content):

(a) Cooperate fully with my HIV program coordinator to confidentially reveal the identity of all persons with whom I have had sex or shared needles for the period starting 3 months prior to my last negative HIV test so contacts may receive counseling and testing to break the chain of transmission. In addition to revealing their identities, I will personally inform my contacts, including my spouse, and recommend they seek medical consultation.

(b) Understand my status is nondeployable and I may not go TDY OCONUS.

(c) Do not donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs.

(d) Follow my UCMJ commander's order by informing all potential sexual partners of my HIV positive status before engaging in intimate sexual contact. My partner will not be under the influence of alcohol, drugs, or prescription medications that could potentially alter his or her judgment during this discussion.

(e) Practice safer sex using a condom or other barrier method recommended by the CDC with every vaginal, penile, anal, and oral sexual encounter. Safer sex practice will not only protect my partners but will also protect me from exposure to other drug-resistant HIV strains.

(f) Notify medical, dental, and emergency health care workers of my HIV infection by stating, " I am blood donor ineligible" or "I have HIV."

(g) Schedule and attend infectious disease clinic appointments every 6 months and more often, as directed by my infectious disease clinic physician.

Note.
ARNG and Reserve Soldiers, unless activated, will have annual fit for duty (FFD) medical evaluations.

(h) Complete DA Form 5669 at diagnosis and annually with my HIV PHN.

(i) Complete the DA Form 4856 at diagnosis, within 30 days of a unit change of command, and within 30 days of every PCS move.

(j) Complete a PHA at diagnosis and annually as coordinated by my HIV PHN.

(k) Contact my current HIV PHN 1 month before PCS for coordination of medical appointments and command requirements with the gaining HIV PHN and in-process with my new HIV PHN at expiration term of service or retirement.

(l) Report all previous donations of blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs to my HIV Program coordinator (PHN).

(m) Understand the health risk and will avoid live attenuated viral immunizations such as intranasal influenza, chicken pox, smallpox, measles, mumps, rubella, yellow fever, and oral typhoid.

b. The commander's copies of the DA Form 5669 and the DA Form 4856 will be maintained in a locked cabinet or storage unit and designated as "Eyes Only" for the commanding officer as long as the Soldier is assigned to that unit. The commanding officer, in situations of Soldier noncompliance, may disclose this information to designated unit senior leadership on a case-by-case basis to support the Soldier toward compliance. For Soldiers PCSing, the HIV PHN will transfer DA Form 5669 and DA Form 4856 by confidential mail or scanned encrypted email to the gaining HIV PHN. The new HIV PHN will complete a new DA Form 5669 and coordinate with the new unit commander to complete DA Form 4856. For unit commanders PCSing, a commander's copy of DA Form 5669 and DA Form 4856 will be provided to the new unit commander and a new DA Form 4856 will be completed.

4–10. Psychosocial counseling

a. HIV infected Soldiers will be referred for a psychosocial assessment and counseling as part of their initial medical evaluation. The purpose of this counseling is to provide an initial assessment of the Soldier's mental state and coping skills.

b. Behavioral health resources may include MTF behavioral health department, pastoral chaplain services, Family life chaplain, Military OneSource, MEDCEN infectious disease social work, and psychiatry.

c. The behavioral health provider and/or Family life chaplain should be skilled at counseling personnel dealing with trauma, depression, and rejection. They should be specifically trained in identifying and dealing with potential suicides and personal grief.

d. HIV infected Soldiers may be referred to psychosocial counseling, as needed.

Section IV
Clinical Evaluations and Recording of Medical Information

4–11. Clinical evaluation, medical profiles, and medical readiness

a. HIV infected Soldiers will be medically evaluated by infectious disease specialists at a participating MEDCEN supporting the health service region to determine the status of their infection.

b. HIV infected RC Soldiers who wish to continue to serve in the RC must prove fitness for duty per medical retention standards of AR 40–501 and be found FFD. RC Soldiers are required to obtain the FFD medical examination from the civilian medical community at no expense to the Government. The required medical procedures will be provided to the Soldier to give to his or her physician. This examination must be repeated at least annually after the initial evaluation (see chap 7 for additional guidance regarding HIV infected RC Soldiers).

c. The CDC classification system for HIV infection will be used for medical classification purposes.

d. Soldiers determined HIV positive by confirmatory test on the first specimen will be noted in MEDPROS as follows: initial physical, upper, lower, hearing, eyes, psychiatric (PULHES) will remain the same, the V code for deployment restrictions will be added to the profile, and medical nondeployment module changed to "YES" by the HIV program coordinator (PHN).

e. Soldiers who are confirmed as HIV infected do not require a change in the PULHES on their physical profile solely because they are HIV infected. If the Soldier's physical or medical condition warrants a change in physical profile, a DA Form 3349 (Physical Profile) will be issued by the MEDDAC/MEDCEN commander or other profiling authority. Copies of the DA Form 3349 will be sent to the unit commander and the servicing personnel service center. Documents will be sealed in an envelope marked "To Be Opened By Addressee Only" and addressed, by name, to the appropriate unit commander and adjutant general or personnel officer. Procedures will be established by the appropriate medical authority to confirm that unit commanders and adjutants general or personnel officers have received proper notification of HIV infected Soldiers. If a change in physical profile is warranted, the following minimum entries will be made on the DA Form 3349:

(1) Item 1 of the DA Form 3349 will indicate the specific medical condition causing the change in physical profile. The profiling authority should avoid referring to HIV infection or retrovirus infection since these terms describe the disease process rather than the specific medical condition resulting in the profile.

(2) Item 2 will contain a V code denoting deployment restrictions and additional codes may be entered as necessary.

(3) Item 3 PULHES, will be adjusted per AR 40–501.

4–12. Blood donation

a. Preventive medicine will report confirmed HIV infected Soldiers to the Army Blood Program look back coordinator, USAMEDCOM for entry into the donor deferral registry.

b. Army blood donor centers will notify local preventive medicine officials about Soldiers who have positive HIV test results identified during blood donation. Test results will include initial reactive or repeat reactive and confirmatory test results.

4–13. Medical records and databases

Information on, and results of, HIV testing will be entered in individual medical records as follows:

a. HIV test dates from the DOD lab contractor go directly to the Armed Forces Health Surveillance Center and are then forwarded to the MEDPROS individual medical readiness.

b. Soldiers with a confirmed positive HIV test (first specimen) will be entered by the installation HIV program coordinator (PHN) until such time that a direct electronic feed is available from the confirmatory lab to MEDPROS. The entry is "initial PULHES will remain the same, the V code will be added to the profile, and medical nondeployment module changed to YES." In the case of a verification test revealing previous erroneous positive result, the HIV coordinator (PHN) will directly coordinate with the regional medical readiness coordinator to correct the MEDPROS database. This allows commanders and medical personnel to track these individuals over time and ensure their continental United States (CONUS) only duty status is not violated.

c. Records pertaining to evaluation and reevaluation of HIV infected Soldiers will be filed per AR 40–66.

d. Soldiers with confirmed positive HIV test (first specimen) will be entered by the installation HIV program coordinator (PHN) in the Armed Services Blood Program Blood Establishment Computer System, a DOD blood management system for tracking donations, testing, and shipping of products and transfusion of blood products.

PREVENTIVE MEDICINE COUNSELING RECORD

For use of this form, see AR 600-110; the proponent agency is DCS, G-1.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority:	5 USC 301, 10 USC 3012(G).
Principal Purpose:	To record preventive medicine counseling of Servicemembers testing positive for exposure to HIV.
Routine uses:	Prerequisite counseling under AR 600-110, paragraph 2-16.
Disclosure:	Disclosure is voluntary. However, failure to provide the information may result in incorrect identification.

INSTRUCTIONS

The counselor will obtain and record the administrative information required in Part I from official military records or from the Soldier's identification card. The HIV program coordinator public health nurse (PHN) will maintain this document in accordance with AR 600-110 in a locked cabinet. Upon PCS, this form will be sent to the gaining HIV program coordinator (PHN). Upon ETS or retirement, this form will be destroyed.

PART I - PATIENT INFORMATION

A. NAME OF PATIENT (Last, First, Mi)	B. DOB	C. GRADE	D. NAME OF SPONSOR
Smith, John Q.	19880101	E6	Same
E. UNIT	**F. LOCATION**		
HHQ, 1st Training BDE	Ft. Knox, KY		
G. DATE OF DIAGNOSIS *(YYYYMMDD)*	**H. DATE AND TIME OF COUNSELING**		**I. LOCATION OF COUNSELING**
20120501	20120503/1330hrs		Ireland ACH, Ft. Knox, KY

J. Counselor:

1. NAME	2. GRADE/CORPS	4. UNIT
Doe, Jane A.	04/MC	A Company IACH Ft. Knox, KY
3. TITLE		
Chief, Preventive Medicine		

PART II - PATIENT COUNSELING ACKNOWLEDGMENT

I have been informed of my positive HIV test result. I understand as a member of the Active Army, Reserve, or Army National Guard, I have specific responsibilities to prevent transmission of the infection to others, specifically:

A. My confirmed positive HIV test means I have been infected with HIV.

B. I understand my UCMJ commander is informed of this positive result and is my advocate in accordance with AR 600-110. I have reviewed and understand my Soldier responsibilities.

C. There is no cure for HIV infection. My blood, semen, vaginal fluids, and breast milk may potentially transmit HIV infections to others. Even if my viral load is undetectable, my blood, semen, vaginal fluids, and breast milk may transmit HIV infection to others.

D. I will not donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs.

E. I am nondeployable, may not go TDY OCONUS, and my career occupational specialty may be affected. My UCMJ commander will contact the HRC HIV POC for guidance.

F. I realize I may have infected others with HIV before I knew I was infected. For this reason, I am obliged to confidentially reveal the identity of all persons with whom I have had sex or shared needles for the period starting 3 months prior to my last negative HIV test, so that contacts may receive counseling and testing to break the chain of transmission. In addition to revealing their identities, I will personally inform my contacts, including my spouse, and recommend they seek medical consultation.

G. Intimate sexual contact includes oral, vaginal, penile, and anal sex with any partner potentially at risk of HIV transmission and infection. The use of condoms may reduce but does not eliminate the risk of HIV infection. I must follow safer sex practices using barriers such as condoms with every sexual act or insist my partners use condoms. Other barriers include female condoms and dental dams. I will not share razors or toothbrushes, and will cover wounds to prevent transmission.

H. Condom use does not remove my obligation to inform partners of my HIV infection before engaging in intimate sexual contact. When discussing this, my partner must not be under the influence of any potentially mind-altering substances (alcohol, illegal drugs, prescription medications, and so forth) that could potentially impair his or her judgment.

I. I understand I must notify medical, dental, and emergency health care workers potentially exposed to HIV infection through contact with my blood and/or body fluids. I understand the need to clarify which vaccines I am receiving and will avoid live attenuated viral immunizations such as intranasal flu, chicken pox, smallpox, measles, mumps, rubella, yellow fever, and oral typhoid vaccines.

J. HIV can be transmitted from an HIV positive mother to her baby; therefore, Family planning issues will be discussed with my infectious disease physician.

K. I will comply with the medical management of HIV infection directed by the infectious disease physician, to include attend medical evaluations every 6 months and as needed (active duty HIV-infected Soldiers only). Note: Army National Guard and Reserve Soldiers, unless activated will have annual fit for duty medical evaluations.

L. I must complete a DA Form 5669 (Preventive Medicine Counseling Record) and DA Form 4856 (Developmental Counseling Form) at diagnosis and as directed by my HIV program director/coordinator (PHN).

M. As a member of the Active Army, Reserve, or Army National Guard, I must complete a periodic health assessment (PHA) at diagnosis, and then annually.

N. To maintain my confidentiality and military requirements, I will contact my HIV program coordinator (PHN) 1 month before PCS, planned expiration term of service, or retirement.

I acknowledge that I, John A. Smith, have been counseled and understand that the preventive medicine measures listed in paragraphs A through N, above, which were explained to me, are necessary to preclude transmission of HIV infections.

O. SIGNATURE OF PATIENT	DATE *(YYYYMMDD)*	P SIGNATURE OF COUNSELOR	DATE *(YYYYMMDD)*
DIGITAL SIGNATURE 12345678	20120503	DIGITAL SIGNATURE 12345678	20120503

DA FORM 5669, JUL 2012 PREVIOUS EDITIONS ARE OBSOLETE. APD LF v1.02ES

Figure 4–1. Sample for DA Form 5669

DX039

Chapter 5
Accession Testing Program

5–1. General
This chapter prescribes the DA policy for accession testing and nonaccession of individuals who are confirmed HIV positive by appropriate confirmatory test.

5–2. Accessions and probationary officers
a. For purposes of this chapter, accessions are—

(1) First enlistments in the AC or RC.

(2) Subsequent enlistments in the AC or RC other than immediate reenlistments in the same component.

(3) Original appointments as a commissioned or warrant officers in the AC (except for officer appointments in the AC under the provisions of AR 601–100, chap 2).

(4) Appointments as cadets at the United States Military Academy (USMA).

(5) First original appointments as commissioned or warrant officers in a RC (to include both qualifications for Federal recognition and for original appointment as a Reserve of the Army in the ARNG following Federal recognition).

(6) Original appointments as warrant officers in the Army of the United States.

(7) Peacetime orders of a member of a RC to AD, active duty for training (ADT), or full-time National Guard duty (FTNGD) for the purpose of attending initial entry training, regardless of whether the RC member is programmed at the conclusion of training for release from active duty (REFRAD), or is programmed to continue on active duty for operational support (ADOS) or FTNGD. This specifically includes the order to ADOS of Reserve commissioned officers commissioned through the Reserve Officers' Training Corps (ROTC) program where the officer's initial duty assignment is to an officer basic course.

(8) Enrollments as an ROTC scholarship cadet or as a nonscholarship cadet in military science III.

(9) Enrollments as an officer candidate (Active Army, ARNG, or USAR) in Officer Candidate School (OCS).

b. Probationary officers are—

(1) AC commissioned officers on the AD list with less than 5 years active commissioned service.

(2) RC commissioned officers who have less than 5 years commissioned service. Both AD and non-AD commissioned service counts.

(3) Warrant officers who have less than 3 years service (AD or non-AD) since original appointment in their present component.

(4) Officers who have less than 3 years service in the Army of the United States without component.

5–3. Human immunodeficiency virus testing policies
a. All applicants for accession (officer, warrant officer, and enlisted for AC and RC) will be screened for HIV using FDA-approved tests.

b. HIV testing of applicants for enlistment will be accomplished during the initial physical examination at the MEPS. Blood samples will be drawn by medical personnel at the MEPS. Testing from any source except MEPS, other DOD military treatment facilities, or DOD contract facilities is not acceptable for accession testing requirements (see AR 601–270).

c. Applicants for accession who have no military status of any kind at the time of testing and who are confirmed HIV infected will not be enlisted or appointed in any component of the Army.

d. Individuals who test HIV positive will be provided a list of civilian treatment facilities by the chief medical officer at the MEPS. The chief medical officer will recommend the individual seek further medical evaluation at one of the listed facilities and complete local health department reporting requirements.

e. Accession testing will be conducted within the first 29 days of AD at training centers, schools, or units (whichever provides the earliest opportunity) for all personnel who have not been previously screened at a MEPS or other authorized location, or for whom 6 months have elapsed from the initial pre-accession screening (such as personnel entering from the delayed entry program or a pre-commissioning program). For accession purposes, the pre-accession HIV test is valid until the Soldier is ordered to AD. Upon order to AD, if the pre-accession test is more than 6 months old, the Soldier will be retested within the first 29 days at the initial AD installation. Those confirmed to be HIV infected will be processed for separation for failure to meet procurement medical fitness standards.

f. Accessions processed by other than MEPS or an initial training center will follow a similar process as outlined above at the military point of entry. Vaccination with live virus vaccines may be administered provided there is a record of a previous negative HIV test no older than 24 months.

g. Prior service personnel required to meet accession medical fitness standards (AR 40–501) must be tested and found to be HIV negative no more than 6 months before enlistment in the Selected Reserve. Prior service applicants, who are not processed through MEPS, may conditionally enlist without an HIV test, or with a test result older than 6

months. Testing is required within the first 30 days after enlistment through the force surveillance testing program. A one-time 30-day extension may be granted by the State Adjutant General or by a commander of one of the numbered armies in CONUS. Soldiers testing HIV positive will be discharged for an existed prior to service medical condition. AD Soldiers transferring to or enlisting in a Selected Reserve unit at the end of their current contractual or statutory obligation without a break in service are required to meet retention medical fitness standards (AR 40–501). These Soldiers must have a negative HIV test no older than 24 months prior to the date of transfer or enlistment.

h. Candidates for active or reserve officer service will be tested during the pre-appointment physical examinations. This applies to any individual pending appointment as an officer in any officer procurement program, to include ROTC, direct commissioning, and OCS (ARNG, Reserve, or Active Army) programs. For accession purposes, the pre-accession HIV test is valid until the Soldier is ordered to AD. Upon order to AD, if the pre-accession test is more than 6 months old, the Soldier will be retested within the first 29 days at the initial AD installation. USMA cadets will be tested within 72 hours of reporting to the USMA on reception day.

(1) USMA cadets who are confirmed HIV positive will be separated from the academy and discharged under USMA regulations. The Superintendent, USMA, may delay separation until the end of the current academic year. If the cadet is in his or her final academic year and is otherwise qualified, the cadet may be graduated without commission and discharged. An honorable discharge will be issued if HIV infection is the sole basis for discharge.

(2) ROTC cadets who are confirmed HIV infected will be disenrolled from the program at the end of the current academic term (semester, quarter, or similar period). Cadets who are disenrolled due to HIV infection will be permitted to retain any financial support received through the end of the current academic term and such support is not subject to recoupment.

(3) Enlisted Soldiers who are officer candidates through OCS and are confirmed HIV infected will be immediately disenrolled from the program. If OCS is the Soldier's initial entry training, the Soldier will be discharged under the provisions of AR 635–200. If OCS is not the Soldier's initial entry training, the Soldier will be removed from the program under the provisions of AR 350–51, AR 140–50, or NGR 351–5, as appropriate, and will be reassigned in his or her original military occupational specialty (MOS) in accordance with assignment policies of chapters 6 or 7. Reassignment will be without regard to PCS restrictions.

5–4. Confidentiality

The provisions of chapters 3, 4, and 9, with regard to confidentiality and use of information, apply to this chapter, except that HIV infection may be used as the basis for separation under the accession testing program. Care will be taken that no one without a "need to know" in the performance of his or her duties is given any information about an applicant's HIV status. "Need to know" individuals are defined as the Soldier's commanding officer, designated laboratory, preventive medicine, behavioral health, pastoral care, pharmacy, wellness, primary care, and specialty medical personnel, Reserve and Guard HIV program directors or coordinators, and designated HRC personnel. In situations of Soldier noncompliance, the commanding officer may disclose this information to the designated unit senior leadership on a case-by-case basis to support the Soldier toward compliance. Current HIPAA privacy and security training is required for all "need to know" individuals.

Chapter 6
Active Duty Personnel Policies and Procedures

Section I
Assignment Policies and Procedures

6–1. General

a. The policies and procedures in this chapter apply to all AD Soldiers, including AGR personnel.

b. Individuals who are confirmed to be HIV infected will be treated with dignity and understanding. Guidance for dealing with the psychosocial aspects of the disease may be obtained from command medical authorities and chaplains.

c. Every effort will be made to ensure that, except for their assignment limitations, HIV infected personnel are treated no differently than other Soldiers. Commanders must ensure that information about the HIV infected Soldier's medical condition is provided only to those whose duties require knowledge of that information (see para 5–4).

6–2. Active force surveillance testing

a. All Soldiers are required to be tested for HIV at least biennially (once every 2 years). Upon confirmation of a positive HIV infection status (after verification specimen) Soldiers are exempt from this requirement.

b. Unit commanders are notified of all personnel requiring biennial HIV testing via MEDPROS.

c. Unless modified by a COCOM, host nation, or other policy that requires earlier testing, personnel who are awaiting a PCS overseas or are scheduled for overseas deployments or TDY must be screened and receive a negative HIV test result if they have not been tested within the 6 months preceding their departure date. Individuals alerted for

overseas assignments will be instructed, as part of their Soldier reassignment processing requirements, to report to the appropriate physical examination clinic or laboratory for a blood sample. For routine HIV testing requirements for RC personnel, see paragraphs 7–2 through 7–6. The following policy applies unless COCOM or host nation's policies require earlier testing (see AR 614–30).

d. In the event that prioritization of testing is required due to resource constraints, screening will be accomplished in the following priority:

(1) Soldiers and military units assigned or pending assignment to areas of the world where a moderate to high risk exists of contracting serious tropical infections, such as yellow fever, malaria, and dengue. Such areas include Central America, South America, the Caribbean, the Philippines, Southeast Asia, Thailand, Malaysia, Central Africa, East Africa, and Southwest Asia.

(2) Soldiers or units pending assignment or deployment to areas of the world where medical support will be limited. Included are assignments to remote areas where periodic evaluation of personnel and monitoring of health will be difficult, such as Korea and the Far East.

(3) Units with contingency plans to deploy on short notice to areas of the world described in paragraphs (1) and (2), above. Included are alerted forces who must be deployed in 30 days or less and all personnel scheduled to participate in overseas exercises that have not been screened within 24 months of the projected deployment date.

(4) Other military units that could be deployed overseas and OCONUS Army Forces in Europe, Korea, and Japan.

(5) All other units.

(6) All Soldiers in conjunction with routine, periodic physical examinations for any purpose, or any other scheduled medical examinations.

6–3. Assignment limitations

a. HIV infected Soldiers will not be deployed or assigned overseas. HIV infected Soldiers will not perform official duties overseas for any duration of time. Soldiers confirmed to be HIV infected while stationed overseas will be reassigned to the United States per paragraph 6–8.

b. In the United States (including Alaska, Hawaii, Guam, Puerto Rico and the U.S. Virgin Islands), HIV infected Soldiers will not be assigned to—

(1) Any table of organization and equipment or modified table of organization and equipment unit. Installation commanders may reassign any HIV infected Soldier in such units to table of distribution and allowances (TDA) units on their installation provided the Soldier has completed a normal tour in that unit (a normal tour for these purposes is 3 years from reporting date to the unit). After completion of a normal tour, reassignment to TDA units may be made provided assignment can be made according to normal personnel management and assignment criteria in AR 614–100 and AR 614–200. Reassignment must be to an authorized position for the Soldier's grade and primary MOS or secondary MOS. Installation commanders unable to make appropriate reassignments will report the names of HIV infected Soldiers to the Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer).

(2) Military-sponsored educational programs, regardless of length but which would result in an additional service obligation. These programs include, but are not limited to, advanced civilian schooling, professional residency, fellowships, training with industry, and equivalent educational programs, regardless of whether the training is conducted in civilian or military organizations. HIV infected Soldiers assigned to these programs will be disenrolled at the end of the academic term in which HIV infection is confirmed and may be reassigned without regard to PCS restrictions. Any financial support received by the Soldier may be retained through the end of the current term of enrollment and will not be subject to any recoupment. In addition, any additional service obligation incurred as a result of attendance at military sponsored educational programs will be waived. Not included in this restriction are military schools required for career progression in a Soldier's MOS, branch, or functional area (such as, Noncommissioned Officer Education System schools, Captains Career Course, or intermediate level education).

(3) U.S. Army Recruiting Command, Cadet Command, U.S. Military Entrance Processing Command, ARNG full time recruiting force, or ARNG full time attrition/retention force if a Soldier's medical condition requires frequent medical follow-up (medical authorities will determine if follow-up is frequent) and the Soldier's projected duty station is geographically isolated from an Army MTF capable of providing that follow-up. These organizations will report HIV infected Soldiers who cannot be assigned per this policy to the Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer), for assignment instructions (AI). For special branch officers, forward assignment requests to HQDA (DAJA–PT) for Judge Advocate General's Corps (JAGC) officers or HQDA (DACH–PEA) for chaplains. For ARNG AGR Title 10 personnel, all requests should be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG FTNGD Title 32 personnel, requests should be sent to the applicable State Adjutant General. Requests for AI for USAR AGR personnel should be sent to Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.

c. Assignment preclusion from units, organizations, schools, or programs other than those listed above must be approved by HQDA (DAPE–HR).

d. Commanders may not change the assignment or utilization of HIV infected Soldiers solely because of their

infection unless required by this regulation or the Soldier's medical condition (as reflected on DA Form 3349 or other pertinent medical records). Grouping all HIV infected Soldiers within a command into the same subordinate unit, duty area, or living area is prohibited unless no other unrestricted units, positions, or accommodations are available.

e. HIV infected Servicemembers may transfer to the Active Army from another Armed Force (inter-Service transfer) if they meet medical retention standards (AR 40–501). However, Servicemembers who are HIV infected may not be transferred to the Army from another Armed Force if they are required to meet accession medical standards (AR 40–501), except as specifically permitted in chapter 5.

f. HIV infected Soldiers who demonstrate progressive clinical illness or immunological deficiency will be processed per section III of this chapter. (See the glossary for definitions of progressive clinical illness and immunological deficiency.)

6–4. Accompanied tours

a. Family members who are HIV infected may accompany their sponsor overseas. Paragraph 8–6 provides guidance for processing HIV infected Family members.

b. When a Family member is HIV infected, the sponsor may request deletion from an overseas assignment alert based on compassionate reasons, or request an "all others" tour. Deletion of the sponsor from overseas AI is not mandated solely based on a Family member's HIV status. If assigned overseas at the time the Family member is diagnosed as HIV infected, the sponsor may apply for a curtailment of foreign service tour (FST) for compassionate reasons per AR 614–30. A mandatory PCS or curtailment of FST of the sponsor will not occur solely because a Family member is determined to be HIV infected.

6–5. Military schooling

Soldiers who are HIV infected and are determined to meet retention standards are eligible for all military professional development schools (such as Noncommissioned Officer Education System, Captains Career Course, and intermediate level education). HIV infected Soldiers may also attend formal military training required to qualify them for reclassification to a new MOS or award a skill qualification identifier, additional skill identifier, or functional area.

6–6. Reenlistment

a. HIV infected enlisted Soldiers who meet medical retention standards of AR 40–501, chapter 3 are eligible to reenlist, if otherwise qualified.

b. There is no requirement to have an HIV test as part of reenlistment qualification unless the Soldier desires to reenlist for an overseas duty assignment or for an organization cited in paragraph 6–3*b*. Soldiers will not be permitted to reenlist for an overseas duty assignment or an organization cited in paragraph 6–3*b*, unless they have tested negative for HIV within the 6–month period preceding the desired date of reenlistment. If HIV infected, they may reenlist for any option in AR 601–280 except overseas or restricted units.

c. Enlisted Soldiers who enlisted or reenlisted for a unit or organization cited in paragraph 6–3*b* and who subsequently are confirmed as HIV infected will be processed as follows:

(1) If otherwise eligible, Soldiers will be advised of the procedures of AR 635–200, concerning requests for separation due to unfulfilled enlistment commitments.

(2) Soldiers who are not eligible for separation due to unfulfilled enlistment commitments under AR 635–200 and who are not under a suspension of favorable personnel actions may request separation for the convenience of the Government under AR 635–200, secretarial plenary authority. These procedures are outlined in paragraph 6–14.

(3) Enlistment contracts may be renegotiated where appropriate and Soldiers, if otherwise eligible, may be given other options commensurate with the established assignment limitations for HIV infected Soldiers.

6–7. Utilization

a. There is no medical reason for HIV infected Soldiers' duties to be changed solely because of their infection (except in certain instances for health care providers). In instances where a Soldier performs duties as a member of a flight crew, or other position requiring a high degree of alertness or stability (for example, explosive ordnance disposal), a case-by-case determination will be made by a medical evaluation board as to the Soldier's fitness to perform his or her duties.

b. In the case of HIV infected health care providers, their duties may be restricted when performing those duties that present a risk of transmitting HIV to their patient. This determination will be made by an expert medical review committee as designated by the deputy commander for clinical services. This committee will make recommendations on a case-by-case basis to the MEDDAC/MEDCEN/Dental Activity commander per AR 40–68 as to the restriction of duties of HIV infected health care providers. The restriction may only be to the extent that the risk is eliminated. In all other instances, HIV infected Soldiers will be utilized in their primary MOS per normal utilization criteria contained in Army personnel regulations and the assignment limitations in paragraphs 6–3*b* and 6–3*d*.

6–8. Assignment/reassignment policies and procedures

a. Overseas policies.

(1) Soldiers serving overseas who are identified as HIV infected will have their FSTs curtailed and will be expeditiously reassigned to the United States. This paragraph does not apply to Soldiers who are permanent residents of and are currently stationed in Guam, the Virgin Islands, or American Samoa. HIV infected Soldiers who are assigned outside these areas and who desire compassionate reassignment to these areas may apply per existing policies for compassionate reassignments. Requests will be considered on a case-by-case basis.

(2) Soldiers who are returned to the United States will have their FST curtailed and will be given credit for a completed tour as prescribed in AR 614–30.

(3) Overseas ACOM, ASCC, or DRU commanders are authorized to approve a second PCS in the same fiscal year for HIV infected Soldiers returning to the United States under this program. AR 614–30 prescribes authorities for approval of PCS and time on station waivers and tour curtailments.

b. Overseas procedures.

(1) Overseas adjutants general or personnel officers will, upon receipt of formal notification of Soldiers who are HIV infected, request immediate FST curtailment per AR 614–30. Curtailments of FST will be coordinated by priority message, "FOR OFFICIAL USE ONLY" with Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer) for AI. For special branch-managed officers, forward assignment requests to HQDA (DAJA–PT) for JAGC officers or HQDA (DACH–PEA) for chaplains. (For ARNG AGR Title 10 personnel, all requests should be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for USAR AGR personnel, all requests should be sent to Commander, U.S. Army Human Resources Command (AHRC–SG), Building 6434–6, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303). Requests will include the following:

(a) Name, grade, social security number, primary MOS or control branch, and unit of assignment.

(b) Include the statement: "This curtailment request is submitted per AR 600–110, paragraph 6–8*b*."

(c) Desired report date.

(d) Three assignment preferences in the United States (including Alaska, Hawaii, Guam, Puerto Rico and the U.S. Virgin Islands) with rationale from the Soldier as to the three choices (for example, to be near Family).

(e) Known assignment limitations or special considerations that should be considered in making the assignment.

(f) Tour type: accompanied, unaccompanied (Family members in the United States), unaccompanied (Family members in-country at sponsor's personal expense).

(2) The Commander, HRC (Commander, National Guard Personnel Center (NGB–ARP–CT), for ARNG Title 10 AGR personnel, or Commander, HRC (AHRC–SGD–H), for USAR AGR personnel) will issue AI expeditiously.

(3) Soldiers overseas identified for referral into the physical disability system will be expeditiously processed per AR 635–40.

(4) Nothing in the procedures discussed above should be interpreted as prohibiting a Soldier from taking leave overseas solely because of HIV infection. Current Army and DOD policy does not restrict a Soldier from any travel in a leave status based on the results of an HIV test. However, HIV infected Soldiers must meet entrance requirements for countries they intend to visit. Countries may require evidence of HIV testing and may require negative test results as part of those entrance requirements.

c. Continental United States policies.

(1) Soldiers identified as HIV infected and who are assigned to organizations cited in paragraph 6–3*b* will be transferred within their current installations. If local reassignment is not possible, HIV infected Soldiers will be reported to the Commander, HRC for AI. These Soldiers are eligible for other assignments in the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands) according to the needs of the Army and existing PCS policies.

(2) Soldiers who receive overseas AI will require an HIV test as part of their Soldier reassignment processing requirements if they have not been tested in the 6 months prior to their port calls. Those who are HIV infected will be deleted from AI. Soldiers with Family members who are HIV infected will follow the policies and procedures in paragraphs 6–4*b* and 8–6.

d. Continental United States procedures. Adjutants general/personnel officers in the United States will, upon receipt of formal notification from the commander of the local MTF of Soldiers who are HIV infected, take the following actions:

(1) Soldiers who are HIV infected will be deleted from overseas AI. For enlisted personnel, requests for deletions will be submitted to the Commander, HRC (AHRC–EPD–I). Approval will be automatic and confirmed through the Enlisted Distribution and Assignment System by HRC. For officer personnel, requests for deletions will be forwarded to the Commander, HRC (TAPC–OPD–M) for officers managed by Officer Personnel Management Directorate; HQDA (DAJA–PT) for JAGC officers; or HQDA (DACH–PEA) for chaplains. For ARNG Title 10 AGR personnel, all requests for deletion will be forwarded to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG Title 32 AGR personnel, all requests for deletion will be forwarded to the State Adjutant General, Support Personnel Management Office, of the particular State/territory to which the

AGR Soldier is assigned for duty. For USAR AGR personnel, all requests for deletion will be forwarded to the Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC-SGD-H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122-5303.

(2) Other than accession testing per chapter 5, enlisted Soldiers undergoing initial entry training (to include prior service Soldiers) with AI to an overseas location and who are confirmed as HIV infected will be reported to the Commander, HRC (AHRC–EPD–I) under provisions of AR 635–200 (see separation for convenience of the Government) for separation if less than 180 days of service or for issuance of AI to an installation in the United States or Puerto Rico if over 180 days of service.

6–9. Transfer of personnel and medical records

The procedures below apply to the transfer of personnel and medical records of all Soldiers identified as HIV infected. These procedures apply to moves within the United States as well as from overseas locations to the United States, excluding those conducted through medical evacuation channels.

a. When AI on an HIV infected Soldier are received, the HIV infected Soldier will inform his or her HIV program coordinator (PHN) and out-process within 30 days of PCS. The losing HIV program coordinator (PHN) will contact the gaining HIV program coordinator (PHN) and provide the expected date of departure, the new assignment location or unit (if known), and the anticipated arrival date, and send the contents of the duplicate file, including all preventive medicine and commander's counseling statements encrypted or by confidential fax to the gaining HIV program coordinator (PHN).

b. The Soldier will in-process with the gaining HIV program coordinator (PHN) immediately upon arrival.

c. The gaining HIV program coordinator (PHN) will ensure that any immediately necessary medical care, to include medical evaluation and reevaluation, is fully coordinated.

d. The HIV program coordinator (PHN) will notify the gaining unit commander of the Soldier's medical condition as soon after his or her arrival as possible.

e. HIV infected Soldiers transferred into a unit will be provided preventive medicine counseling and commander's counseling in the same manner as that prescribed for newly identified HIV infected Soldiers (see paras 4–8 and 4–9).

f. Soldiers who are returning to the United States from overseas for initial medical evaluation at the regional infectious disease service will be ordered, as part of HRC (AHRC–SG) for USAR AGR Soldiers' AI, to report TDY en route to the regional Army MEDCEN for the new assignment location for a period not to exceed 10 days. HRC will ensure that the AI includes instructions to provide a copy of the PCS orders to the designated MEDCEN. Soldiers who will be accompanied by Family members will be counseled that housing for the Family at the TDY location will be at the Soldier's own expense and that Government transient quarters may not be available. Soldiers referred to medical or physical evaluation boards immediately following medical evaluation will be handled per normal medical or physical evaluation boards procedures and will be deleted from their original orders. The MEDCEN HIV program coordinator (PHN) will notify the gaining installation HIV program coordinator (PHN) of pertinent medical information telephonically or by encrypted email.

6–10. Monitoring patient health

a. Long-term monitoring of the HIV infected individual's health is essential. Clinical evaluation will be accomplished at least twice a year by an infectious disease specialist at a participating MEDCEN. Commanders should be advised if AD Soldiers fail to comply with treatment instructions, preventive medicine counseling, or orders given during the commander's counseling.

b. The attending physicians or medical POCs must inform the Soldier's commander when a significant change in immunological status or clinical disease status is identified. Likewise, commanders must consult the attending physician or medical POC if the Soldier's FFD becomes suspect. Soldiers thought to be unfit for duty will be processed through normal medical or physical evaluation boards for determinations.

c. When HIV infected Soldiers are attached to another unit for a period in excess of 15 days, their commanders will personally notify the gaining unit commander of the Soldier's medical condition. The gaining commander will maintain this information confidentially and will release that information only to those with an established "need to know" of the medical condition.

Section II
Procedures

6–11. Overseas

a. The medical activity commander and/or division surgeon—

(1) Provides formal notification to the unit commander and the adjutant general or personnel officer having custody of an HIV infected Soldier's Army Military Human Resource Record (AMHRR).

(2) Expeditiously schedules HIV infected Soldier for a second verification HIV test, medical evaluation at the designated regional MEDCEN, and referral to the HIV program coordinator (PHN) at the gaining CONUS installation.

b. The adjutant general or personnel officer having custody of the AMHRR of HIV infected Soldiers—

(1) Requests FST curtailment per AR 614–30.

(2) Expeditiously processes AI issued by HRC (National Guard Personnel Center for ARNG personnel or HRC for USAR AGR personnel) and issues necessary orders.

(3) Follows procedures prescribed in paragraph 6–8*b*.

c. The CG, HRC—

(1) Issues AI for Soldiers identified as HIV infected.

(2) Directs award of tour credit in the special instructions of the AI.

d. For ARNG AGR personnel, the Commander, National Guard Personnel Center, will use the procedures described for CG, HRC, in paragraph *c*, above.

6–12. Continental United States

a. The HIV program director—

(1) Provides formal notification to the unit commander and the adjutant general or personnel officer having custody of the AMHRR of HIV infected Soldiers.

(2) Ensures that Soldiers are referred into the physical disability system in coordination with the infectious disease physician, as appropriate.

b. Adjutants general or personnel officers having custody of the AMHRR of HIV infected Soldiers—

(1) Request deletion of those Soldiers who are on overseas AI.

(2) Reassign locally those Soldiers who are infected and are assigned to organizations cited in paragraph 6–3*b*. Request AI in those cases where on-post transfer cannot be accomplished to satisfy assignment policy limitations.

(3) Follow the procedures described in paragraph 6–8*d*.

c. The CG, HRC—

(1) Approves deletion requests for HIV infected Soldiers who are on overseas AI.

(2) Upon request, issues AI for those Soldiers in organizations cited in paragraph 6–3*b* who cannot be reassigned locally.

d. For AGR personnel, the following individuals will perform those procedures described for the CG, HRC, in paragraph *c*, above.

(1) The Commander, National Guard Personnel Center for ARNG personnel on NGB-controlled Title 10 tours.

(2) The State Adjutants General for ARNG personnel on Title 32 tours.

(3) The Commander, HRC (AHRC–SGD–H) for all USAR personnel.

Section III
Administrative Separations

6–13. Administrative separation of officers

a. Officers who are HIV infected and no longer desire to remain on AD may submit an unqualified resignation under the provisions of AR 600–8–24 or request voluntary REFRAD under the provisions of AR 600–8–24, as appropriate. Probationary officers (as defined in AR 600–8–24) who have tested positive for HIV infection and who were infected prior to acceptance of appointment may request resignation under the provisions of AR 600–8–24.

b. Officers submitting voluntary applications for resignation or REFRAD should use the formats indicated in AR 600–8–24, as appropriate. The officer will execute the following statement and include it in his or her application: “I have been counseled by a member of The Judge Advocate General’s Corps regarding the consequences of my request and I certify that this request is voluntary. I understand that if my request is accepted, I will be granted an honorable discharge (if requesting resignation) or honorable characterization of service (if requesting REFRAD).” Officers who are HIV infected but still meet medical retention standards and desire to be discharged must be counseled by a member of The Judge Advocate General’s Corps, who will explain the impact of the officer’s request. As a minimum, specific information regarding the officer’s post-discharge eligibility for medical care will be provided. A copy of the counseling statement will accompany the request for separation. The counseling statement will contain the following statement, as a minimum: “Officer was advised that disability benefits under provisions of 10 USC 61 may be available in the event that he or she remains in the Army until the U.S. Army Physical Disability Agency determines the officer is no longer fit to perform assigned military duties.”

c. Requests for resignation or REFRAD will be submitted through command channels to the appropriate career manager indicated below:

(1) Maneuver, fires, and effects (formerly combat arms)—Commander, U.S. Army Human Resources Command (HRC–OPA), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(2) Operation support division (formerly combat support arms)—Commander, U.S. Army Human Resources Command (HRC–OPB), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(3) Field services division (formerly combat service support)—Commander, U.S. Army Human Resources Command (HRC–OPC), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(4) Health services to health services division—Commander, U.S. Army Human Resources Command (HRC–OPH), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(5) Colonels to senior leader division—Commander, Headquarters, Department of the Army (DACS–CMO), 200 Army Pentagon, Washington, DC VA 20310–0200.

(6) Chaplains—Headquarters, Department of the Army (DACH–PER), 2700 Army Pentagon, Washington, DC 20310–2700.

(7) JAGC officers—Headquarters, Department of the Army (DAJA–PT), 200 Army Pentagon, Washington, DC 20310–2200.

(8) AGR Officers—For ARNG Title 10 AGR officers, Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG Title 32 AGR officers, State Adjutant General, Support Personnel Management Office; and for USAR AGR officers, Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.

d. AC commissioned and warrant probationary officers entering AD who are identified as HIV infected within 180 days of their original appointment, or USAR and ARNG commissioned and warrant probationary officers who report for initial entry training in an AD (other than ADT) status and are identified as HIV infected within 180 days of reporting to AD, will be processed for discharge under the provisions of AR 600–8–24.

e. Officers who are HIV infected and have been found not to have complied with preventive medicine counseling prescribed in paragraph 4–8 may be involuntarily discharged. Commanders may recommend that such officers be eliminated under the provisions of AR 600–8–24. Recommendations for separation must be based upon information obtained independently from interviews or surveys conducted in conjunction with the epidemiologic assessment process. Other than the fact that an officer is HIV infected and has been counseled regarding preventive medicine procedures, no other information related to the assessment process will be used to support involuntary separation. Evidence of unprotected intimate sexual behavior, drug abuse, or other violations of the preventive medicine procedures must be derived from sources not related to the assessment process.

f. Examples of independently derived evidence include, but are not limited to, urinalysis tests conducted under the Alcohol Substance Abuse Program (ASAP), noncompliance with the medical management of HIV infection as determined by an infectious disease physician, or the routine diagnosis of STIs other than HIV.

g. HIV infected officers remain subject to involuntary separation under any provision of AR 600–8–24, as appropriate. The policies described in chapter 9 apply. Officers who no longer meet medical retention standards will be processed per AR 635–40.

6–14. Administrative separation of enlisted personnel

a. Enlisted Soldiers who are HIV infected may submit a voluntary request for discharge under the provisions of AR 635–200, secretarial plenary authority. Voluntary requests for separation will be submitted through command channels to Commander, U.S. Army Human Resources Command (AHRC–EPF–M), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303. (For ARNG Title 10 enlisted AGR personnel, requests will be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450. The National Guard Personnel Center will forward these requests to HRC for decision. Requests from ARNG Title 32 enlisted AGR personnel will be sent to the State Adjutant General, Support Personnel Management Office, of the particular State/territory in which the Soldier is assigned for duty. For USAR AGR enlisted personnel, requests will be sent to Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.) Requests for voluntary separation will not be accepted from Soldiers who no longer meet medical retention standards of AR 40–501. Such Soldiers will be processed for medical separation under the provisions of AR 635–40.

(1) HIV infected Soldiers who still meet medical retention standards and desire to be discharged must be counseled by a member of The Judge Advocate General's Corps, who will explain the impact of the Soldier's request. As a minimum, specific information regarding the Soldier's post-discharge eligibility for medical care will be provided. A copy of the counseling statement will accompany the request for separation. The counseling statement will contain the following statement, as a minimum: "Soldier was advised that disability benefits under provisions of 10 USC 61 may be available in the event that he or she remains in the Army until the U.S. Army Physical Disability Agency determines the Soldier is no longer fit to perform assigned military duties."

(2) Soldiers desiring discharge will complete a DA Form 4187 (Personnel Action) and execute the following statement: "I request discharge from the Army under the provisions of AR 635–200, secretarial plenary authority, for my own convenience. I have been counseled by a member of The Judge Advocate General's Corps regarding the consequences of my request, and I certify that this request is voluntary. I understand that, if my request is accepted, I will be granted an honorable discharge."

(3) Requests for separation must include certification that the Soldier is HIV infected but meets medical retention

standards. Commanders endorsing requests for separation under the provisions of paragraph *a*, above, will verify the Soldier's medical condition and that the Soldier still meets medical retention standards.

b. Soldiers identified as HIV infected within 180 days of initial entry on AD will be separated under the provisions of AR 635–200 for failure to meet procurement medical fitness standards.

c. HIV infected enlisted Soldiers found not to have complied with preventive medicine counseling prescribed in paragraph 4–8 may be involuntarily separated. Commanders may recommend that such enlisted Soldiers be separated under the provisions of AR 635–200, under either secretarial plenary authority, or for acts or patterns of misconduct, as the unit commander deems appropriate. The following procedures apply:

(1) If the Soldier is processed for separation under the provisions of AR 635–200, secretarial plenary authority, the notification procedure (AR 635–200) will be used to notify the Soldier that his or her discharge is being recommended. Soldiers processed for separation under the provisions of AR 635–200 for acts or patterns of misconduct, will be notified of the recommendation for discharge under administrative board procedures (AR 635–200) or the notification procedure (AR 635–200), as appropriate.

(2) Recommendations for involuntary separation must be based upon information that is not obtained through interviews or surveys conducted in conjunction with the epidemiologic assessment process. Other than the fact that a Soldier is HIV infected and has been counseled regarding preventive medicine procedures, no other information related to the assessment process will be used to support involuntary separation. Evidence of unprotected intimate sexual behavior, drug abuse, or other violations of the preventive medicine procedures must be derived from sources not related to the assessment process.

(3) Examples of independently derived evidence include, but are not limited to, urinalysis tests conducted under the ASAP, noncompliance with the medical management of HIV infection as determined by an infectious disease physician, or the routine diagnosis of STIs other than HIV.

(4) Recommendations for involuntary separation under the provisions of AR 635–200 and recommendations for involuntary separation of Soldiers with 18 or more years of service will be forwarded to Commander, HRC (AHRC–EPF–M), for processing. (For ARNG Title 10 enlisted AGR personnel, requests will be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG Title 32 enlisted AGR personnel, requests will be sent to the State Adjutant General, Support Personnel Management Office, of the particular State/territory in which the Soldier is assigned for duty. For USAR enlisted AGR personnel, requests will be sent to Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.) As a minimum, recommendations for separation must include documentation of the notification process (to include the Soldier's acknowledgement of notification), statements submitted by the Soldier and/or his or her counsel, certification that the Soldier has been counseled regarding preventive medicine measures, and details/evidence of the Soldier's failure to comply with those measures.

d. HIV infected enlisted Soldiers remain subject to involuntary administrative separation under any provision of AR 635–200; however, Soldiers who no longer meet medical retention standards will not be involuntarily separated except under AR 635–200 (see misconduct; in lieu of trial by court-martial; dishonorable and bad conduct discharges; limitations on referral to the Physical Disability Evaluation System; and administrative separations).

6–15. Disability separation

a. HIV infected military personnel who demonstrate progressive clinical illness or immunological deficiency as determined by medical authorities, do not meet medical retention standards of AR 40–501 and may be processed for separation per AR 40–501 and AR 635–40.

b. While infectious disease medical evaluation will not serve as the sole criteria for determining medical fitness or a disability rating, the clinical manifestations that determine a stage of the disease's severity may, in fact, contribute to determining a Soldier's fitness for duty. All HIV infected Soldiers who show signs of immunological deficiency or a progressive illness must be referred to medical evaluation boards regardless of the clinical stage of the disease. This should result in a more expeditious status determination that will benefit both the Soldier and the Government.

Chapter 7
Reserve Components Personnel Policies and Procedures

Section I
Introduction

7–1. General

This chapter prescribes policies and procedures for HIV testing pertaining to ARNG and USAR personnel performing duty under USC Title 10 and USC Title 32, to include Active Guard and USAR (AGR refer to chap 6). These policies and procedures are intended primarily to apply to troop program units (TPUs); however, the policies and procedures

also pertain to the USAR Standby Reserve (active and inactive) and individual mobilization augmentee (IMA). Current HIPAA security and privacy training is required for "need to know" individuals (see para 5–4).

7–2. Testing requirement for National Guard and Reserve Soldiers applying for tours of active duty

a. Personnel ordered to AD for more than 30 days including travel time (for example, ADT, AGR, initial AD for training, and ADOS) must have been tested for HIV with negative results no more than 2 years prior to the report date and prior to issuance of orders. In rare situations where this requirement cannot be met, orders will include the following statement: "You will obtain a HIV test from a designated military facility en route to, or immediately upon, arrival at your duty station. If your HIV test status is not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate."

b. Under mobilization conditions (as declared by Congress or executive order and implemented by DOD), the Assistant Secretary of the Army (Manpower and Reserve Affairs) may authorize HIV infected RC Soldiers to be ordered to ADOS. If ordered to ADOS, RC Soldiers known to be HIV infected will be assigned and utilized within the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands). RC Soldiers identified as HIV positive during mobilization station testing will be immediately REFRAD. Specific guidance will be provided in the Personnel Policy Guidance.

c. Personnel ordered to AD with duty oversees for more than 30 days including travel time (for example, ADT, AGR, initial AD for training, and AD for special work) must have been tested for HIV antibodies with negative results 180 days prior to the report date and prior to issuance of orders. In rare situations where this requirement cannot be met, orders will include the following statement: "You will obtain a HIV test from a designated military facility en route to, or immediately upon, arrival at your duty station. If your HIV test status is not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate." Soldiers identified at power projection platform or during deployment and mobilization as HIV infected after verification test validates will be REFRAD.

Section II
Policies and Procedures

7–3. General

a. HIV testing and retention policies will be consistent with all DOD and DA policies and regulations.

b. HIV testing should remain available for all Soldiers upon their request without inquiring as to the reason for the test. However, testing for USAR Soldiers will be at no additional cost to the Government if not event driven. Reserve Soldiers can request HIV testing at an MTF by contacting the HIV program coordinator at HRC.

c. The HIV testing program is accomplished primarily during periodic physical examinations, physical health assessment, or periodic Soldier readiness processing.

7–4. Testing timeline requirements

a. General.

(1) Testing of all nonprior service Soldiers will be accomplished upon appointment, enlistment, or induction.

(2) Testing of all AD Title 10 and Title 32 USC Soldiers will be accomplished every 2 years. Upon confirmation of HIV infection status (after verification specimen) Soldiers are exempt from this requirement.

(3) RC personnel not on AD are required to have current HIV test every 2 years. Upon confirmation of HIV infection status (after verification specimen) Soldiers are exempt from this requirement.

(4) HIV testing for ARNG personnel during State emergency duty will be accomplished in conjunction with post deployment health assessment before ARNG personnel are de-mobilized from State emergency duty.

(5) RC personnel performing AD Title 10 or Title 32 USC for 30 days or less are required to have a current HIV test, unless HIV infection has previously been confirmed.

(6) RC personnel will be screened when called to a period of AD greater than 30 days if they have not received an HIV test within the last 2 years.

(7) HIV infected Soldiers will not be permitted to serve in the IRR. Those in the USAR, when so identified, will be processed per paragraph 7–12. HIV infected AD Soldiers leaving AD who have a contractual or statutory obligation remaining will be transferred to the USAR control group (Standby).

(8) Personnel located OCONUS scheduled for training either in the United States or overseas who do not meet the testing windows stated above will be tested immediately upon arrival at the training duty station when testing prior to departure is impractical.

b. Transferring components.

(1) HIV testing of all ARNG Soldiers transferring from one RC to another, or to the IRR, will have a HIV negative test within 2 years. This does not apply to HIV infected Soldiers exercising their option to voluntarily transfer to the Standby or Retired Reserve.

(2) HIV testing of all personnel who transfer from another Service or USAR control group into the ARNG, including members of the Inactive National Guard, will have a HIV negative test within 2 years.

7–5. Reserve component surveillance testing

a. ARNG and USAR Selected Reserve screening will be conducted every 2 years.

b. ARNG and USAR Soldiers will also undergo HIV screening as part of their periodic physical examinations or physical health assessment. AD Soldiers may not refuse screening, but should be informed of the pending procedure. Soldier privacy will be maintained in the same manner as required in AC MTF procedures.

c. If prioritization of testing is necessary, screening will be accomplished in the same order as in paragraph 6–2*d*. RC Soldiers ordered to AD for more than 30 days will be considered priority 4 if they do not meet the criteria of priorities 1 to 3.

d. ARNG and USAR TPU surveillance testing will normally be accomplished as part of the periodic physical examination or physical health assessment.

e. Soldiers assigned to the IRR and IMA programs will be tested during annual training (AT) or ADT if their last HIV test is older than 2 years, and during periodic physical examinations or physical health assessment, including flight physicals. IRR and IMA Soldiers' physical examinations or physical health assessments that are performed by civilian contract will be considered "interim complete" if the Soldier has a documented HIV test no older than 2 years. Under this circumstance, an HIV test will be required within 48 hours of reporting for any AD period to ensure the physical examination is updated.

f. IRR and IMA Soldiers not on AD who require testing or are participating in overseas deployment for training will be tested in MTF facilities or by the Reserve Health Readiness Program contracted authorized providers. Those IRR and IMA Soldiers who require periodic medical examinations or PHAs will be tested in MTF facilities or by authorized contract providers.

g. For USAR Soldiers, HIV test results will be annotated on DD Form 2808 (Report of Medical Examination), item 49, if testing occurred as part of a physical exam. If testing occurred separately from a physical exam, results will be annotated on Standard Form (SF) 600 (Medical Record - Chronological Record of Medical Care). DD Form 2808 and SF 600 will be posted in the Soldiers' medical records. Compliance with HIV testing is in the MEDPROS individual medical readiness record.

h. HIV test dates are electronically transferred into the MEDPROS individual medical readiness record.

7–6. Human immunodeficiency virus testing for reserve component on active duty

a. All RC personnel ordered to AD for more than 30 days under Title 10 or Title 32 USC programs, to include AGR, will be required to have a current HIV test with negative results. Testing will occur within 2 years of a CONUS assignment or within 180 days for an OCONUS assignment. Testing must occur prior to the report date and issuance of orders, including travel time. In rare situations where this requirement cannot be met, orders will include the following statement: "You will obtain a HIV test from a designated military facility en route to, or immediately upon, arrival at your duty station. If your HIV test status is not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate."

b. According to Department of Defense Instruction (DODI) 6490.03, every deployed Soldier will have a baseline blood serum drawn and placed in the DOD Serum Repository, Armed Forces Health Surveillance Center, within 12 months before the Soldier actually deploys. The Soldier must be informed that this serum will be tested for HIV en route to the repository. This is a separate requirement from the HIV test required within 2 years before deployment (or closer to deployment if mandated by COCOM or other appropriate policies).

7–7. Priority for testing

a. Soldiers who are scheduled for overseas PCS will be tested prior to PCS.

b. Testing will be based on the priorities listed in paragraph 6–2*d*.

c. For RC Soldiers mobilized on short notice, the guidance in paragraph 7–6 will be followed. If a Soldier does not have a negative HIV test within the required period of time prior to mobilization, then an HIV specimen will be drawn immediately upon issuance of orders. Specimens should be processed and shipped to the DOD designated laboratory overnight by the collection site for processing. Routinely, the designated laboratory will process the specimens with 24 to 48 hours of receipt and results will return to the RC usually with 7 to 10 days. If a State is mobilizing troops and needs the results back immediately, the State HIV POC can mark the shipment "PROCESS IMMEDIATELY, need for MOBILIZATION." Screening HIV test results will normally be available within 48 hours, but may be delayed due to logistical limitations. Soldiers will not be mobilized until test results are known. If the test results are negative, the Soldier is considered available for mobilization. If the initial test results are positive, the Soldier will be removed from further processing until independent verification tests are conducted and results are known. HIV positive test results generally are available within 72 hours.

7–8. Roles and responsibilities

a. The Chief, NGB; CG, HRC; and CG, USARC are responsible for implementation of HIV testing of RC Soldiers in accordance with this regulation.

b. The State Adjutants General of each ARNG State and territory and USARC will—

(1) Appoint an HIV program director/manager to develop State (HRC) testing plans for notification and counseling procedures, reporting and recording of test data, and procedures for periodic follow-up.

(2) Ensure that medical patient confidentiality is maintained per laws and regulations and specifically ensure that there are no unwarranted disclosures of information concerning an individual's medical condition.

c. The ARNG and HRC HIV program director will—

(1) Perform the duties of a contract officer technical representative for the RC centrally funded HIV testing contract. Ensure that HIV testing services and funding are appropriated in accordance with the HIV contract.

(2) Produce and distribute specific HIV testing information to the HIV program manager or deputy State surgeon for State distribution.

(3) Track and report the number of HIV infected Soldiers in the ARNG to the Chief National Guard surgeon and in the USAR to the CG, USARC on a monthly basis.

(4) Serve as designated backup at the headquarters level for the NGB in the event the State POC cannot be reached during the notification phase of a positive HIV test result from the laboratory or AC HIV program director or coordinator.

d. The State (AHRC–SG) HIV program manager will—

(1) Be responsible for coordination and notification of Soldier HIV testing results with the individual, the unit commanders, the State surgeon, regional support command, operational and functional commands, the HIV program director, and the local health department.

(2) Coordinate to obtain the second independent verification specimen to be tested for HIV in a USAMEDCOM designated laboratory. A second specimen is required through the USAMEDCOM designated laboratory even if the Servicemember self identifies after testing positive in a civilian setting.

(3) Track, update, and protect the annual FFD status of all HIV infected Soldiers in the State and USAR on a monthly basis.

(4) Ensure that all HIV testing on Soldiers assigned to the State and USAR is conducted in accordance with this regulation.

(5) Ensure maximum participation with minimal interruption of mission training. The State HIV program manager will identify testing locations by month, date, and quantities of blood samples to be submitted according to the testing contract. The minimum number of testing sites necessary to accomplish the mission will be utilized in order to reduce the overall cost of the centrally funded contract. Order, maintain, and distribute HIV testing supplies for all HIV testing requirements, in accordance with this regulation, within the State and State emergency duty locations.

(6) Maintain transmittal sheets matching names, social security numbers, and units with laboratory numbers. Ensure that the transmittal sheets will be confidentially handled as medical records.

(7) Coordinate the notification of all State and USAR HIV infected personnel in accordance with this regulation and the positive HIV test notification checklist.

(8) Order, manage, and maintain HIV testing supplies for all Soldiers and State Home Land Defense and Home Land Security missions.

e. Unit commanders will—

(1) Ensure that all personnel in their units are tested in accordance with this policy.

(2) Ensure that the HIV infection and/or AIDS information and education requirements in chapter 10 are included in unit training programs. This training will be conducted annually and will be documented in command training records. Commanders are encouraged to use TDA Army Medical Department (AMEDD) officers, mission and funds permitting. If AMEDD officers cannot be used, trainers may be members of the chain of command, assigned officers or enlisted Soldiers, or nonmilitary personnel from outside sources.

7–9. Army National Guard notification and counseling procedures

a. The results from testing will be returned by the designated HIV testing laboratory to the State designated HIV program director and/or coordinator. All positive HIV tests will be verified by a second independent blood draw. However, the Soldiers must be notified and counseled in accordance with this regulation upon the first positive HIV test.

b. ARNG Soldiers who are HIV infected will be notified and counseled in accordance with chapter 4. All HIV infected ARNG Soldiers and their spouses will be individually and privately notified of all positive HIV test results in a face-to-face interview by a designated and qualified AMEDD officer within the State, in accordance with chapter 8. All HIV infected ARNG Soldiers and their spouses will be counseled regarding the significance of a positive HIV test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. HIV infected ARNG Soldiers will be referred to civilian physicians for medical care and further counseling. The telephone number of local

civilian health authorities will be given to Soldiers if information on local physicians or facilities is requested (for notification and testing of ARNG HIV infected Soldiers' spouses see chap 8).

c. Individuals tested at MEPS for accession purposes or component transfers will be notified of HIV positive test results by the examining physician or other appointed, qualified counselor. Soldiers tested at MEPSs as part of a periodic physical examination (space available basis) will be notified of HIV positive test results through the Soldier's unit physician or chain of command.

d. The Soldier, commander, and medical corps officer will be in official status (inactive duty training, Reserve special training, ADT, AT, or ADOS) at the time of notification(s), counseling, and blood drawing.

e. ARNG positive HIV test notification checklist must include the following:

(1) Has the State HIV program manager been notified?

(2) Has the State HIV program manager reviewed this regulation?

(3) Before the Soldier is contacted, has the Soldier's original HIV test sample been tested and clinically indicated using an approved FDA test?

(4) Has the Soldier been notified in a face-to-face interview, by a physician or designated health care provider, and counseled via the DA Form 5669 and DA Form 4856 and chapter 4?

(5) Once the Soldier has been notified about the clinical indication of a HIV positive test results, has the Soldier's blood been re-drawn for a second independent verification specimen, using an approved FDA test method?

(6) Was a copy of the test result given to the Soldier during the face-to-face notification?

(7) Has the State HIV program manager reported to the local public health authorities?

(8) Has the Soldier been medically evaluated to determine the status of his or her infection and FFD?

(9) Has the Soldier been informed that he or she must provide a valid copy of an annual FFD examination performed by a qualified physician to the State HIV program director and/or coordinator?

7–10. U.S. Army Reserve notification and counseling

a. The results from testing will be returned by the designated HIV testing laboratory to the HRC Surgeon's Directorate HIV program manager. All positive HIV tests will be verified by a second independent blood draw. However, the Soldiers must be notified and counseled in accordance with this regulation upon the first positive HIV test.

b. USAR Soldiers who are HIV positive will be notified and counseled in accordance with chapter 4, as applicable. All HIV positive USAR Soldiers and their spouses will be individually and privately notified of all positive HIV test results in a face-to-face interview by their unit commander and telephonically counseled by a qualified AMEDD officer in accordance with chapter 8. All HIV infected USAR Soldiers and their spouses will be counseled regarding the significance of a positive HIV test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. HIV infected USAR Soldiers will be referred to civilian physicians for medical care and further counseling. The telephone number of local civilian health authorities will be given to Soldiers, if information on local physicians or facilities is requested. For notification and testing of USAR HIV infected Soldiers' spouses see chapter 8.

c. All Soldiers, including IRR, whose initial HIV test is positive, will be notified of the results in a face-to-face interview, by a physician or designated health care provider and counseled via the DA Form 5669 and DA Form 4856 and chapter 4.

d. The HRC HIV program manager will coordinate with the USARC G–1 HIV program manager for a physician or designated health care provider, if necessary, to notify IRR or IMA initial HIV positive Soldiers.

e. Training and information packets will be provided by the USARC POC G–1 HIV program director. Spouses of confirmed HIV infected USAR Soldiers will be notified of the positive test results. The USAR will issue the spouse invitational orders to accompany the Soldier to notification.

f. Physicians or designated health care providers supporting notification to Soldiers with HIV positive test results will refer information provided about spouses or partners with whom the Soldier may have had at-risk contact to the HRC program manager for notification to local public health officials, as prescribed by State and local laws, for further notification and management.

g. HIV infected USAR Soldiers not on ADOS will be counseled regarding the significance of a positive HIV test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. They will be referred to civilian health care providers for medical care and further counseling. Chapter 8 provides guidance for offering HIV testing and counseling to spouses of HIV infected USAR Soldiers.

h. All of the information contained in paragraph 4–8 and on DA Form 5669 will be covered and copies of the record will be provided to the individual Soldier and commander (or designated commander's representative, if the commander is a general officer) at the time of notification. The counselor's copy will be forwarded through the HIV program POC (regional support command or operational and functional command) channels through the USARC POC to the HRC program manager. Notification to public health authorities will be per procedures published by USARC and per State and local law. All records will be forwarded in a sealed envelope marked "To Be Opened By Addressee Only" via command channels and addressed specifically to the USARC HIV program manager by name. Physicians

performing notification and Soldiers notified of an initial or subsequent positive HIV test will be in an official status (inactive duty training, rescheduled training, ADT, AT, ADOS) at the time of notification.

i. The unit commander of the initial HIV positive USAR TPU Soldier will be immediately available at the time the Soldier is notified by the physician or designated health care provider. Immediately following the preventive medicine counseling, the commander will counsel the Soldier per paragraph 4–9 and complete DA Form 4856. The counseling statement will be destroyed if the Soldier is determined to be uninfected by verification tests.

7–11. Reporting and recording of information

a. Recording of the results of HIV testing will be per chapter 4.

b. Collection procedures and reporting of information for inclusion in the DOD data base will be per chapter 4, section IV.

c. Notification to commanders of results of an FDA-approved testing will be per paragraph 4–3.

d. Notification to public health authorities will be per procedures published by NGB, USAR, and per State and local law.

7–12. Assignment and personnel actions

a. Soldiers confirmed to be HIV infected, but who manifest no evidence of progressive clinical illness or immunological deficiency, will not be separated solely on the basis of their HIV infection. HIV infected Soldiers, not AGR or ADOS may prove fitness for service. HIV infected AGR personnel will complete a medical evaluation to determine if they are FFD. ADOS Soldiers will be processed for involuntary REFRAD upon confirmation of HIV infection. During the REFRAD processing the Soldier may initiate the FFD requirement. HIV infected Soldiers will have 120 days from the date they are notified of their infection to complete a medical evaluation to determine fitness per the established DOD protocol for HIV or other guidance published by OTSG or OCAR. HIV infected Soldiers found to be medically unfit for duty will be separated per paragraph 7–13. Soldiers found fit will be permitted to serve in the Selected Reserve in a nondeployed billet, if available. Grade, MOS, and commuting constraints are applicable per existing regulations. Soldiers meeting fitness standards and placed in nondeployable billets must be re-evaluated at least annually. Initial and subsequent evaluations will be at the Soldier's expense and will be provided by the Soldier to the State or HRC HIV program manager for recording in the individual medical record. Soldiers may request transfer to the Standby Reserve, Retired Reserve (if eligible), or Honorable Discharge under the plenary authority of the Secretary of the Army in lieu of continued service. (See AR 135–175 for resignation of officers and warrant officers who do not meet the medical fitness standards at time of appointment, or AR 135–178 for voluntary separation of enlisted Soldiers on indefinite reenlistments.)

b. HIV infected Soldiers will be involuntarily transferred to the inactive Standby Reserve, following a case-by-case assessment, if they—

(1) Fail to complete the initial or annual medical evaluation in the prescribed period.

(2) Are found fit, but cannot be placed in a Selected Reserve nondeployable billet per grade or MOS.

(3) Are in a Selected Reserve nondeployable billet and do not complete the annual medical evaluation for fitness for duty.

c. The mere fact of HIV infection, in and of itself, will not be used as the basis for—

(1) Disciplinary action against the individual under the UCMJ or State code.

(2) Adverse characterization of service.

(3) Nonselection for a vacant nondeployable billet.

d. Unit commanders who initiate action to transfer HIV infected Soldiers to the USAR control group (Standby) will do so under the provisions of AR 140–10.

e. Assignment and retention policies for ARNG Soldiers who are AGR or on ADOS and are HIV infected will be carried out per chapter 6.

f. HIV infected RC Soldiers will not be ordered to a tour of duty for more than 30 days, nor extended on a tour of duty if the extension will cause the total length to exceed 30 days except under mobilization conditions and as authorized by the Assistant Secretary of the Army (Manpower and Reserve Affairs) (see para 7–2*b*).

g. HIV infected USAR Soldiers who are ordered to AD for over 30 days and identified as positive after verification will be REFRAD.

7–13. Separation procedures

a. HIV infected ARNG Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards will be processed under AR 40–501 and NGR 600–200 or NGR 635–101, as appropriate.

b. HIV infected USAR Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards under AR 40–501 will be processed per AR 135–178 (enlisted) or AR 135–175 (officer).

7–14. Education

a. Training. Unit commanders will ensure that the HIV and/or AIDS information and education requirements in chapter 10 are included in unit training programs. This training will be conducted annually and will be documented in command training records. Commanders are encouraged to use TDA AMEDD officers, mission, and funds permitting. If AMEDD officers cannot be used, trainers may be members of the chain of command, assigned officers or enlisted Soldiers, or nonmilitary personnel from outside sources.

b. Individuals seeking additional information may refer to the following resources:

(1) DCS, G–1 HIV policy and deoxyribonucleic acid (DNA) registration at http://www.armyg1.army.mil/hr/hivdna/.

(2) The USAPHC Health Promotion and Wellness Portfolio has HIV and STI prevention information resources found at http://phc.amedd.army.mil/Pages/default.aspx. The CDC divisions of HIV and/or AIDS prevention, National Center for HIV/AIDS, Viral Hepatitis, STI, and tuberculosis prevention Web site has information resources at http://phc.amedd.army.mil/topics/healthyliving/rsbwh/Pages/HIVandSTDPrevention.aspx.

Chapter 8
Family Member and Civilian Personnel Policies and Procedures

Section I
Human Immunodeficiency Virus Testing for Family Members and Other Health Care Beneficiaries

8–1. Testing of Family members and other health care beneficiaries

Family members and other HCBs may not be compelled to have an HIV test. However, an HIV test may be ordered by a physician or designated health care provider as part one of the clinically indicated laboratory tests required to adequately treat the patient. Patients should be routinely informed that the physician or designated health care provider will order any clinically indicated laboratory tests necessary to include testing for HIV infection unless the patient specifically declines such tests.

8–2. Human immunodeficiency virus testing program components

An HIV test may be clinically indicated for Family members and other nonmilitary HCBs seeking medical care under the circumstances listed below. Those who test HIV positive will be offered medical evaluation and counseling per paragraphs 4–8 and 4–10.

8–3. Consent requirements

HCBs not on AD will be verbally informed by their health care provider of clinically indicated laboratory tests, including HIV testing, required in the course of their medical evaluation. After discussion, HCBs may opt-out of HIV testing. The HCB will not be denied care as a result of refusing HIV testing. However, the HCB will be advised that an assessment of the medical condition for which care is sought may be incomplete.

Section II
Family Member and Other Health Care Beneficiaries Policies and Procedures

8–4. Notification procedures

a. All HCBs and spouses of HIV infected Soldiers will be individually and privately notified of any positive HIV test result in a face-to-face interview with their ordering physician or designated health care provider.

b. The designated physician or health care provider will notify HCBs of the initial positive HIV test. The individual will be informed that he or she has a positive HIV test, that it may mean he or she is infected by HIV and, if confirmed to be infected by a second or subsequent test, he or she will be referred for further medical evaluation. Individuals will be advised not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs and to refrain from sexual relations until the results of the verification tests are available. Test results of Family members will not be reported to the sponsor's command authorities. The Family member and the sponsor will be advised of the results and counseled per paragraph 4–8 by medical personnel.

c. Notification of contacts of HIV infected personnel will be as follows:

(1) HCBs who are sexual partners of individuals who are HIV infected, or individuals who were transfusion or blood product recipients from HIV infected donors will be advised by medical authorities to seek medical evaluation as soon as possible.

(2) Information should be reported to civilian public health authorities, per local jurisdiction reporting requirements, when information is obtained through the epidemiological assessment interview indicating individuals who—

(a) Are not military personnel or military HCBs who are/were sexual partners of known HIV infected individuals.

(b) Were transfusion or blood product recipients from HIV infected donors.

d. Information pertaining to HIV infected spouses will be reported through designated channels to local public health authorities. For spouses of AD Soldiers, the HIV program coordinator (PHN) will report that information to local public health authorities per local jurisdiction reporting requirements. OTSG will publish guidance for reporting this information. For spouses of RC Soldiers, information will be provided to the State or to the numbered armies in CONUS HIV program POC. That information will, in turn, be provided to the State or local jurisdiction public health authority dealing with HIV and/or AIDS per State or local law or reporting requirements. The NGB and OCAR will publish guidance for reporting this information.

8–5. Testing of spouses of human immunodeficiency virus infected Soldiers

a. Spouses of Active Army Soldiers will be notified of their sponsor's HIV infection by the Soldier and notification confirmed by the preventive medicine HIV program coordinator (PHN). The HIV program coordinator (PHN) will recommend that the spouse be tested for HIV. However, such testing is voluntary. If the spouse chooses to be tested, the HIV program coordinator (PHN) will ensure that appropriate preventive medicine counseling is conducted. DA Form 5669 is not used for Family member counseling.

b. Spouses of RC Soldiers are normally not HCBs. However, spouses of HIV infected RC Soldiers may be designated by the Secretary of the Army as limited HCBs for purposes of receiving HIV testing and counseling, if approved. The NGB and USARC will publish procedures for informing spouses of HIV infected RC Soldiers of the sponsor's infection and for offering voluntary HIV testing and counseling. See chapter 7 for RC personnel policy.

8–6. Accompanied tours

Family members who are HIV infected are not restricted by this policy from accompanying their sponsor overseas; however, host nation rules apply. If initial diagnosis of a Family member occurs while at an overseas location, the Family member will be encouraged to undergo immediate detailed medical evaluation. Test results of Family members will not be reported to the sponsor's command authorities. The Family member concerned will be advised of the results. Notification of Family member's test results to anyone other than the Family member will be provided only in accordance with local jurisdiction reporting and notification requirements. If clinical illness is present or evaluation is desired, the Family member will be processed for medical evacuation to the Army MEDCEN designated and will ordinarily be returned to the overseas location on completion of evaluation.

8–7. Exceptional Family Member Program

When a Family member of an AD Soldier is confirmed as HIV infected or diagnosed with AIDS, either by testing through the MTF or by a civilian practitioner, the primary physician or a member of the HIV clinical staff will notify the Exceptional Family Member Program (EFMP) POC case coordinator for initiation of enrollment in the EFMP per AR 608–75. The primary physician or a member of the HIV clinical staff will counsel the Family member and the sponsor concerning the requirement for mandatory enrollment in the EFMP. The EFMP POC case coordinator, in coordination with the HIV clinical staff, will process the Family member to ensure confidentiality.

8–8. Child, Youth and School Services

a. Placement of an HIV infected child into Army-sponsored Child, Youth and School Services programs will be determined on a case-by-case basis. The goal of the placement decision is to provide the optimal setting for care based on the overall health status of the child. Factors which will be considered in the decision include neurological development, behavior, and immune system status. Consideration will also be given to special circumstances in which the protective environment of a special purpose Family child care home would be more appropriate (that is, need for stringent infection control procedures to protect an HIV infected child from communicable disease).

b. The placement decision will be made by the installation Special Needs Accommodation Program team consisting of the child's parents; PHN; Child, Youth and School Services coordinator; EFMP coordinator; and the Army Community Services director. The PHN will contact the child's physician prior to the Special Needs Accommodation Program team meeting to ensure the child's safety and medical concerns are adequately addressed and to meet the child's safety needs in the least restrictive environment. If this team is unsure of the appropriate placement decision, additional personnel at the MEDCEN servicing that installation's health service region or the installation's management agency region ACOM, ASCC, or DRU headquarters may be consulted. Confidentiality of the information regarding the child and his or her parents will be maintained by all personnel involved in the decision.

c. Knowledge of the child's HIV status will be limited to those who have a legitimate need for that confidential information per HIPAA and taking into account the following:

(1) Specific infection control procedures needed to protect the child or the child's care givers.

(2) Home health procedures dictated by the child's medical treatment plan.

(3) The need for a supportive environment due to developmental, neurological, or behavioral deficiencies.

Section III
Civilian Employees Policies and Procedures

8–9. Testing of civilian employees

a. Normally, neither applicants for employment nor current employees may be required to be tested for the presence of HIV and, if no such host nation requirement exists, care should be taken to ensure that DA civilians' pre- and post-deployment serum specimens are not tested for HIV. However, pursuant to DOD guidance, HIV testing may be authorized when it is required by a host country. Determination of host nation HIV testing requirements will be the responsibility of the employer. Any such testing will be at no cost to the employee. Assignment or employment may be denied to employees who refuse to comply with this testing requirement, or who have a positive HIV test result. Prior approval to require a civilian employee to be tested for HIV must be obtained from Headquarters, Department of the Army (DAPE–CPE), 300 Army Pentagon, Washington, DC 20310–0300, when it is determined that a host country requires proof of negative HIV test results. Requests for approval to require an employee to be tested to meet host country requirements must include documentation of the testing requirement. Requests for exception to the testing policy may not be approved by DA. All requests for exceptions to the testing policy will be forwarded through command channels to Headquarters, Department of the Army (DAPE–CPE), 300 Army Pentagon, Washington, DC 20310–0300 for review and staffing. DA will forward to DOD and request approval of all justified host nation civilian testing requirements and will provide notification of the results of the request to the requesting activity.

b. DA will provide civilian employees who are overseas and authorized medical care at Army MTFs the opportunity to be tested for the presence of HIV on an elective, space-available basis. Positive HIV test results will be confidential information and will not be the basis of any adverse actions concerning the individual's employment (see para *c*, below). Employees and their Family members will be encouraged to obtain further diagnosis or treatment.

c. The presence of HIV and/or AIDS will not, by itself, be the basis of any adverse personnel action against an employee. Existing civilian employment policy provides guidance relating to appropriate action when employees are not physically able to carry out the duties of their job.

d. In the case of HIV infected health care providers, their duties may be restricted when performing those duties that present a risk of transmitting HIV to their patient. This determination will be made by an expert medical review committee as designated by the deputy commander for clinical services. This committee will make recommendations on a case-by-case basis to the MEDDAC/MEDCEN/Dental Activity commander, per AR 40–68, as to the restriction of duties of HIV infected health care providers. The restriction may only be to the extent that the risk is eliminated.

e. Because of the small, but important, risk of health care providers contracting blood-borne infections, such as HIV, all civilian health care workers will be encouraged to be tested periodically, particularly those employees exposed frequently to blood or body fluids from patients.

f. Civilian health care providers sustaining a laceration or needlestick injury with possible transmission of disease will be advised to be tested following injury and at periodic intervals and to be followed medically. Of particular concern are instances where blood or body fluids from an HIV infected patient may be accidentally introduced into the employee. Such employees should be immediately referred to the emergency department for HIV post-exposure prophylaxis evaluation per CDC guidelines. They should be tested at the time of the incident, at 3 months, and again at 6 months after exposure to detect seroconversion in latent infections resulting from the accidental exposure. Employees tested outside the MTF should provide follow-up test results to the MTF occupational medicine provider.

8–10. Guidelines for handling issues related to human immunodeficiency virus infection and Acquired Immune Deficiency Syndrome

a. These guidelines are intended to assist managers and supervisors of civilian employees in dealing with HIV and/or AIDS related personnel issues arising in the workplace. They provide managers and supervisors of civilian employees a basic framework on how to approach and resolve such issues. Specific technical advice and assistance should be obtained from the servicing civilian personnel advisory center (CPAC), MTF, and legal office in resolving individual cases.

b. Guidelines issued by the Public Health Service's CDC dealing with HIV and/or AIDS in the workplace state that "the kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HIV and/or AIDS." Therefore, employees in the workplace who have been diagnosed as, or suspected of being, HIV infected must be allowed to continue working as long as they are able to maintain acceptable performance and do not pose a risk of substantial harm to the health or safety of themselves or others that cannot be eliminated or reduced by reasonable accommodation. If serious performance or safety problems arise, supervisors and managers should address them by applying existing Federal and Army civilian personnel policies and practices.

c. There is no medical basis for employees refusing to work with fellow employees or agency clients who are, or are suspected of being, HIV infected. Nevertheless, the concerns of employees who fear working with HIV infected co-workers should be taken seriously and should be addressed with appropriate information and counseling. In addition, employees, such as health care providers, who may come into direct contact with HIV infected persons, or with their body fluids, should be provided appropriate information and equipment to minimize the risks of such contact.

d. Managers and supervisors should treat HIV infected employees in the same manner as employees who suffer from other serious illnesses. This means, for example, that employees may be granted sick leave or leave without pay when they are incapable of performing their duties or when they have medical appointments. An employee with HIV and/or AIDS-related conditions may be an "individual with a disability " under the Rehabilitation Act of 1973, as amended, (29 USC 701), the Americans with Disabilities Act, as amended (42 USC 12101), the Americans with Disabilities Act Amendments Act (PL 110–325), and Equal Employment Opportunity Commission regulations and may be entitled to "reasonable accommodation." Managers and supervisors are encouraged to consult with their local legal offices to determine their rights and obligations in any specific cases.

e. Consistent with DA's concern for employees with HIV and/or AIDS infection, the following resources are available:

(1) Management and employee education and information on specific life-threatening illnesses through the activity MTF.

(2) Referral to agencies and organizations which offer support services for personnel with HIV and/or AIDS through the ASAP civilian counseling services, MTF, or the ASAP civilian services employee assistance program screening counseling and referral services.

(3) Benefits consultation from the civilian personnel office to assist employees in effectively managing health benefits, leave, insurance, and other benefits.

f. When dealing with situations involving an employee with HIV and/or AIDS, managers and supervisors should—

(1) Understand that HIV and/or AIDS will not, absent other considerations, be the basis for taking any adverse personnel action against an employee.

(2) Remember that information concerning an employee's health is personal and confidential, and it is covered by the Privacy Act. Accordingly, such information can be released only to agency officials who have a need to know. Further, supervisors and management officials should ensure that precautions are taken to protect all information regarding an employee's health. All information concerning an employee's health must be kept separate from the employee's personnel file and treated as a confidential medical record. (See AR 40–66 and AR 340–21.) Any questions concerning disclosure of such information should be directed to the local staff judge advocate.

(3) Contact the MTF HIV program coordinator (PHN) for information about a specific life-threatening illness or the contagious nature of an illness. The servicing CPAC also should be contacted regarding additional guidance in providing reasonable accommodations for an employee with HIV and/or AIDS.

(4) Contact the MTF program coordinator (PHN) if it is determined additional information should be obtained from the employee's physician to assist in determining if the employee's presence at work will pose any threat to the employee or co-workers.

(5) Be understanding, compassionate, and sensitive to the fact that continued employment for an employee with a life-threatening illness may sometimes be therapeutically important in the remission or recovery process, or may help to prolong the employee's life.

(6) Encourage employees with HIV and/or AIDS to seek assistance from established community support groups for medical treatment and counseling services. Information on these services can be requested through the ASAP, HIV program coordinator (PHN), and/or employee assistance programs.

(7) Be sensitive and responsive to co-workers' concerns, and emphasize employee education available through CPAC and MTF. Give no special consideration beyond supplying appropriate information, counseling, or training to employees who feel threatened by an HIV infected co-worker. Disciplinary action may be taken against any employee whose refusal to work with an HIV infected employee causes disruption in the workplace.

Chapter 9
Limited Use Policy

9–1. Purpose

The purpose of this chapter is to specify limitations on the use of information regarding HIV testing results and medical evaluation.

9–2. Limitations on the use of laboratory test results

a. Test results confirming that a Soldier is HIV infected may not be used against the Soldier—

(1) As the basis for any disciplinary or adverse administrative action, except for the following:

(a) Separation for physical disability. However, Soldiers who are HIV infected but are determined by medical authorities to show no sign of progressive clinical illness or immunological deficiency will not be separated for physical disability solely because of HIV infection.

(b) Separation under the accession testing program of Soldiers meeting the definition of accession (chap 5).

(c) Separation as specifically authorized by paragraphs 6–13 through 6–15.

(2) As a basis for an unfavorable entry in a personnel record (see para 9–5).

(3) To characterize service.

b. This policy does not impose any other restrictions on the use of test results within DOD. Nothing in the restrictions in paragraph *a*, above, precludes the use of such laboratory test results in any other manner consistent with law or regulation including—

(1) To establish the HIV infection status of a Soldier who disobeys the preventive medicine counseling, the commander's counseling, or both, in an administrative or disciplinary action based on such disobedience.

(2) To establish the HIV infection status of a Soldier as an element of any other permissible administrative or disciplinary action (for example, as an element of proof of an offense charged under the UCMJ).

(3) To establish the HIV infection status of a Soldier as a proper ancillary matter in an administrative or disciplinary action (for example, as a matter in aggravation in a court-martial in which the HIV infected Soldier is convicted of an act of rape committed after he is informed that he is HIV infected).

c. Laboratory test results will receive the same protection as any other medical information per AR 40–66. Medical authorities are required to report test results indicating that a Soldier is HIV infected to the Soldier's chain of command. Although the use of this information by commanders is not limited except as described above, commanders will treat the information with due regard for the privacy of the Soldier concerned.

9–3. Limitations on the use of certain other information

a. As part of the effort to control the spread of HIV infection and to develop medical and scientific information concerning the infection, AD Soldiers (including AGR and other Reservists who, because of their status, are entitled to military medical care) who are identified as HIV infected will be questioned by medical authorities concerning possible sources of their exposure to the virus. This medical evaluation process is called an epidemiological assessment. Information that a Soldier may provide to medical authorities during this assessment may not be used against the Soldier or other named third parties except as authorized by this paragraph. Such protected information includes, for example—

(1) Information concerning a Soldier's personal use of drugs.

(2) Information concerning consensual homosexual or heterosexual activity, even if that sexual activity is prohibited by law or regulation.

b. Information obtained during, or as a result of, an HIV epidemiological assessment may not be used against the Soldier or other named third parties—

(1) In a court-martial.

(2) In a nonjudicial punishment action (Article 15, UCMJ).

(3) In a line of duty determination.

(4) As a basis, alone or in conjunction with other information, for the involuntary separation of a Soldier, except a separation for physical disability. If the information is used in a physical disability separation procedure, the information may not be used on the issue of whether the disability was due to the Soldier's own misconduct.

(5) In an administrative or punitive reduction in grade.

(6) For denial of a promotion.

(7) In a bar to reenlistment.

(8) As the basis for an unfavorable entry in a personnel record.

(9) As a basis, in whole or in part, to characterize service or to assign a separation program designator.

(10) In any other action considered to be an adverse personnel action (for example, comment in DA Form 67–9 (Officer Evaluation Report) or DA Form 2166–8 (NCO Evaluation Report)).

9–4. Exclusions

The limitations in paragraph 9–3 on the use of information do not apply to the following:

a. The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse or relevant sexual activity (or lack thereof) has been first introduced by the Soldier.

b. Disciplinary or other action based on independently derived evidence.

c. Nonadverse personnel actions such as—

(1) Reassignment.

(2) Disqualification (temporary or permanent) from a Personnel Reliability Program.

(3) Denial, suspension, or revocation of a security clearance.

(4) Suspension or termination of access to classified information.

(5) Removal (permanent or temporary) from flight status or other duties requiring a high degree of alertness or stability (for example, explosive ordnance disposal) or restricting the duties of HIV infected health care providers.

d. Any evidence or information derived from sources independent of an epidemiological assessment. For example,

admissions of drug abuse or sexual misconduct by an HIV infected Soldier, not made in the context of an epidemiological assessment, may be used as evidence in an administrative or disciplinary action against the Soldier.

9–5. Entries in personnel records

In the event that personnel actions are taken as a result of, or are supported by, evidence of HIV infection, or information described in paragraph 9–3, care will be taken to ensure that no unfavorable entry is placed in a personnel record in connection with the action. Recording a personnel action in a personnel record is not itself an unfavorable entry in such a record. Also, information that reflects an individual has serologic or other evidence of HIV infection is not an unfavorable entry in a personnel record.

Chapter 10
Human Immunodeficiency Virus Information and Education Plan

10–1. General

This chapter establishes—

a. The minimum requirements for providing information and education about HIV to the Total Army Family.

b. Responsibilities to ensure that the HIV information and education program is successful.

c. Resources available to the Army community in carrying out this information and education plan.

d. See chapter 7 for RC policy.

10–2. Plan components

The HIV information and education plan consists of the following five components:

a. Prevention of HIV, STIs, and unintended pregnancies for Soldiers.

b. Training for UCMJ commanders.

c. Awareness training about Army HIV policies and bloodborne pathogen prevention for health care workers.

d. Training of HIV program directors, coordinators (PHN), and staff.

e. Army Family member education, as needed, based on resources.

10–3. U.S. Army Public Health Command

The USAPHC will develop standardized training and education programs for Soldiers, commanders, health care workers, HIV program directors/coordinators and staff, and community groups using current CDC guidelines and adult learning principles. The Chief Nurse, USAPHC is designated as the HIV and/or AIDS education program coordinator to facilitate implementation of the HIV education program.

10–4. Human immunodeficiency virus education plan for the military community

a. In collaboration with commanders, MTF staff, the public affairs officer, civilian personnel representatives, and other interested installation agencies, the HIV program coordinator (PHN) will implement the standardized training and education programs developed by USAPHC.

b. To execute the HIV education plan for the military community, the following responsibilities are assigned:

(1) The CG, U.S. Army Training and Doctrine Command will ensure that existing health awareness/education blocks of instruction in all Army schoolhouse and initial entry training courses incorporate basic HIV and/or AIDS instruction. This instruction should focus on prevention of HIV, STIs, and unintended pregnancies for Soldiers which place an individual at high risk of exposure to HIV, methods of transmission, measures to protect against exposure, and Army requirements for HIV testing.

(2) Installation commanders will ensure implementation of training for UCMJ commanders, and ensure Soldiers receive AT on prevention of HIV, STIs, and unintended pregnancy. To ensure HIV education programs reach all targeted personnel, classes will be included in the installation's master training calendar.

c. Supervisors of civilian employees will ensure that all civilian employees receive training on HIV infection and AIDS in the workplace, so that employees understand—

(1) The medical ramifications of HIV and/or AIDS as they relate to communicability, and as they affect an employee's ability to perform official duties.

(2) Workplace rights of employees who are HIV positive or have AIDS.

(3) Civilian employees may be excused from HIV and/or AIDS in the workplace training if they believe the training is offensive or may be emotionally or psychologically stressful to them. Managers and supervisors who excuse civilian employees from scheduled training will offer those employees appropriate alternatives to the training, such as written materials on HIV and/or AIDS in the workplace. (Chap 8 provides guidance for handling HIV and/or AIDS in the workplace issues.)

(a) For Family members, HIV education should include an emphasis on high risk behaviors and methods of

preventing infection, including safer sex instruction. Family member education may be accomplished in conjunction with a variety of other installation activities to include—

(b) Community counseling centers.

(c) Health care facilities caring for Family members.

(d) Recreation centers.

(e) Libraries.

(f) Chapel or religious education activities.

(g) Chaplain Family Life Centers.

(h) Youth activity programs.

(4) Unit commanders will ensure that their Soldiers attend at least one HIV education class annually. They will request assistance from their servicing medical facilities, as needed, to comply with this requirement. (See chap 7 for RC policy.)

(a) Because of individual rotation and to provide flexibility in scheduling, commanders will ensure that HIV education is offered at least quarterly. The education plan will be incorporated into the unit's quarterly training schedule.

(b) RC units may conduct this training annually prior to unit testing.

(5) Commanders at all levels will make HIV education a matter of special interest within their organizational inspection programs. The goal of the review should be to assess the existence and effectiveness of installation and unit education programs.

10–5. Educating and training health care providers

OTSG is responsible for ensuring that education and training programs are implemented for health care providers. Included in this group are health educators, primary care providers, STD interviewers and counselors, drug and alcohol counselors, and occupational safety and health personnel. Education for these individuals should focus on enabling them to perform their duties following the guidelines published by the CDC and the Occupational Safety and Health Administration. Their training should also equip them to provide counseling to at-risk patients as a normal part of their duties. MTF commanders are responsible for implementing HIV education and training for health care personnel at their installations per the education plan developed by OTSG.

10–6. Resources

CDC and USAPHC have additional information on their Web sites on HIV and STD prevention.

a. CDC divisions of HIV/AIDS prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and tuberculosis prevention Web site at http://www.cdc.gov/std/.

b. The USAPHC Health Promotion and Wellness Portfolio has HIV and STD prevention information resources available at the following Web site http://phc.amedd.army.mil/topics/healthyliving/rsbwh/Pages/HIVandSTDPrevention.aspx.

Chapter 11
Law Enforcement and Corrections Policies and Procedures

Section I
Army Law Enforcement and Security Personnel

11–1. Purpose

This section provides policies and procedures for Army law enforcement and security personnel to prevent duty-related exposure to HIV infection. The information contained herein is consistent with model HIV policies published by the CDC.

11–2. Precautionary measures against duty-related exposure

As first responders, Army law enforcement and security personnel will frequently encounter situations in which they come in contact with body fluids or objects contaminated with HIV. Examples include serious traffic accidents, injuries, and crimes of violence (murder, rape, robbery, aggravated assault). In situations where exposure to body fluids is likely or possible personnel will take the following precautions:

a. Wear impermeable gloves (rubber or latex).

b. Wear eye protection.

c. Exercise caution to avoid punctures or cuts.

d. Wear protective over garments to include footwear and head gear.

e. Use caution when searching and wear heavy-duty gloves to avoid puncture wounds.

f. Cover and protect open wounds, cuts, and irritations from possible contamination.

g. Use one-way airway devices when administering mouth-to-mouth resuscitation.

h. Use sealable plastic bags to collect soiled and stained items consistent with established crime scene processing procedures (AR 195–5).

i. Avoid or minimize direct contact with body fluid spills or potentially contaminated objects. Should contact with body fluids occur, wash exposed areas with soap and hot water as soon as possible and seek medical evaluation.

11–3. Clean-up and disinfecting procedures

a. Personnel will follow these procedures when cleaning potentially HIV infected items and areas:

(1) Avoid direct contact with soiled or stained items.

(2) Clean spills and stains with approved solutions (1:10 bleach to water mix).

b. In addition, the personal hygiene measures outlined below should be applied after potential exposure:

(1) Avoid eating, drinking, or smoking until after cleaning up.

(2) Shower the entire body with soap and hot water as soon as possible after exposure.

(3) Launder or dry clean soiled clothing before wearing them again.

11–4. Availability of equipment and supplies

a. Installation Directors of Emergency Services and commanders must ensure that all personnel have ready access to protective and decontamination equipment and supplies including—

(1) Impermeable gloves (rubber or latex).

(2) One-way airway devices (adult and pediatric sizes).

(3) Sealable plastic bags.

(4) Suitable protective over garments.

(5) Heavy-duty gloves (for conducting searches).

(6) Decontamination solution (household bleach).

b. The use of disposable items is recommended.

11–5. Actions following possible direct exposure

Installation Directors of Emergency Services and commanders must immediately refer potentially exposed personnel for medical examination and evaluation. They will also ensure exposed personnel comply with follow-up medical evaluations and ensure proper documentation of event and follow-up. Commanders will develop and implement a post exposure prophylaxis plan in consultation with supporting infectious disease and preventive medicine physicians.

11–6. Orientation and training

Army law enforcement and security personnel will attend awareness training on the causes, methods of transmission, and prevention of duty-related HIV infection at least annually. This requirement does not exempt military personnel from the HIV education requirements of chapter 10. Training will be developed in concert with the local MTF and must reflect the basic tenets of DA policy on HIV as outlined in this regulation. (Special attention will be directed toward ensuring law enforcement and security personnel are properly trained on the use of one-way airway devices.) This training will include realistic demonstrations and hands-on practical exercises. Newly assigned personnel will attend training prior to being utilized for operational law enforcement or security duties.

11–7. Policy implementation

Installation Directors of Emergency Services and commanders will develop and implement standard operating procedures necessary to implement the requirements of this regulation. However, in clearly life-threatening situations, the inability to comply with the foregoing policies and procedures, or the lack of prescribed equipment or supplies, is insufficient justification to either delay or deny emergency aid or assistance. First responders are expected to use sound judgment and good common sense in applying these policies.

Section II
Army Corrections System Policies and Procedures

11–8. Human immunodeficiency virus in correctional facilities

HIV has become a major policy and management issue for correctional administrators. Correctional institutions have become a focus of concern for this infection.

11–9. Purpose and applicability

The information and guidelines contained in this section have been developed for correctional staff to assist in the identification and management of prisoners infected with HIV. The policies presented are intended to provide overall guidance in preventing the transmission of HIV within the Army Corrections System as well as protecting the

confidentiality of HIV infected prisoners and reducing the anxiety and misunderstanding about the disease within the Army Corrections System.

11–10. Prisoner testing program

a. All prisoners will be tested for HIV within 24 hours of entering confinement. Prisoners at low risk for HIV infection may be placed in general population while waiting results of tests through routine DOD channels. Prisoners who are determined to be HIV negative will be retested at least annually as part of a program to monitor and detect any transmission of HIV in the facility.

b. Should incidents which could result in the transmission of HIV (for example, sexual contact, tattooing, intravenous drug use, or body fluid transfer) occur in confinement or correctional facilities within the Army Corrections System facilities, the participants will be immediately tested for HIV. If all of the participants are known to be HIV infected, testing is unnecessary. In incidents where at least one of the participants is found to be, or is known to be, HIV infected, all HIV negative prisoners involved in the incident will be retested for HIV at 3 months and 6 months from the date of the incident.

c. Any prisoner who, at any time, shows clinical signs or symptoms of HIV infection as determined by medical authorities will be tested for HIV.

d. Any prisoner who has, or acquires, an STI will be tested for HIV unless medical authority determines testing is unnecessary.

e. Except in cases where HIV testing has been done for other reasons within 90 days of their release dates, all prisoners will be retested for HIV within 30 days of their scheduled date of release from confinement.

f. HIV testing of any inmate may be considered any time the confinement or correctional facility commander, in coordination with the MEDDAC commander, deems it necessary for the safe operation of the facility or health and welfare of the personnel (prisoners and staff) in his or her command.

11–11. Confidentiality

Results of all HIV tests must be kept confidential. Personnel who have access to medical, dental, and correctional records will have current HIPAA privacy and security training. Only those personnel, designated by the facility commander, with a legitimate need to know which prisoners are HIV infected will be informed. Correctional treatment files and other correctional records will not be annotated to reflect the inmate's HIV infection. The electronic medical record will document the Soldier's HIV infection. Prisoners who are HIV infected will be discouraged from telling anyone other than medical, psychological, and dental personnel. Any statements made by prisoners in military and/or correctional records to the effect that they are HIV infected will remain in such records and will not be expunged. Normally, only medical records may contain indications that an inmate is HIV infected.

11–12. Prisoner transfers

All prisoners who are transferred from one Army or Sister Service correctional facility to another will be accompanied by a letter of transmittal from the losing facility commander to the gaining facility commander. The letter of transmittal will inform the gaining facility commander of the prisoner's medical condition. Paragraph 6–9 provides additional guidance for the facility commanders. If a prisoner is transferred with HIV test results pending, those results will be forwarded to the gaining facility commander by preventive medicine personnel as soon as possible per paragraph 4–4.

11–13. Prisoners returning to confinement

All prisoners who return to confinement after having been absent from the facility (temporary home parole, parole revocation, trial by or otherwise in the custody of civil authorities) will be considered for retesting. Factors to be considered include whether the inmate was in a geographic area with a high incidence rate of HIV infection or other high risk situation.

11–14. Prisoner requested testing

Prisoners who voluntarily request HIV testing will be medically evaluated and counseled by appropriate medical staff prior to, and after, being tested.

11–15. Medical center evaluation

a. Within 7 calendar days after receiving results that an inmate is HIV infected, the commander will schedule the prisoner for evacuation to a MEDCEN for initial medical evaluation, counseling, treatment, and other medical attention, as necessary. Immediately following such evaluation and appropriate treatment, the prisoner will be returned to the designated confinement or correctional facility.

b. All HIV infected prisoners will be reexamined and reevaluated by an infectious disease specialist from a participating MEDCEN at least twice per year, or as determined necessary by local medical authorities. The examination will be accomplished at a MEDCEN or the correctional facility, as appropriate.

11–16. Medical management in confinement

a. All HIV infected prisoners will be evaluated and managed on a case-by-case basis per CDC guidelines.

b. The medical condition of HIV infected prisoners will be monitored by the local MEDDAC. Frequency of medical visits will be every 4 to 6 weeks, or as deemed appropriate by medical authorities.

c. All HIV infected prisoners will be provided emotional and psychosocial support by counselors trained in working with HIV infected individuals.

d. Immediately prior to any HIV infected prisoner's release from confinement, military preventive medicine authorities will report applicable information to civilian public health authorities for the State into which the prisoner will be released. Reporting will be per applicable statutes of that State.

11–17. Routine confinement practices

a. HIV infected prisoners will not be segregated from the general inmate population based solely on the fact they are HIV infected.

b. Normally, the handling of laundry and linen of HIV infected prisoners will be no different than for other prisoners. In certain cases, determined by medical authorities, special handling of contaminated laundry or linen may be necessary.

c. Toilet and shower facilities for HIV infected prisoners will not be separate or different from those used by other prisoners in the same custody grades.

d. Food service sanitation provisions for HIV infected prisoners will be no different or separate from that of other prisoners, to include dishwashing and garbage handling procedures.

11–18. Work, training, restoration, parole, and clemency

a. HIV infected prisoners will be assigned to work and training programs per AR 190–47 and this regulation.

b. Recommendations for clemency and parole should not be made based solely upon HIV seropositivity.

11–19. Segregation of human immunodeficiency virus infected prisoners

a. HIV infected prisoners who fear being with the general inmate population will be considered for, and may be placed in, administrative segregation. Upon their request, and as deemed necessary by the facility commander, they may be placed in protective custody.

b. All HIV infected prisoners who are (beyond mere suspicion) sexually active, sexually aggressive, or otherwise physically aggressive, may be placed in administrative segregation in single cells. They should not be permitted to eat, work, train, or have recreation with any other inmate.

11–20. Transfer of human immunodeficiency virus infected prisoners

a. HIV infected prisoners in the Army Corrections System will not be transferred to other confinement or correctional facilities, or centrally confined at any one facility, based solely on their HIV infection status, unless deemed necessary by medical authorities.

b. HIV infected prisoners who medical authorities deem in need of special medical attention will be transferred to the U.S. Disciplinary Barracks. They will be maintained in administratively segregated, special quarters inside the U.S. Disciplinary Barracks. HIV infected prisoners within 90 days of release from confinement will normally not be transferred to the U.S. Disciplinary Barracks. HIV infected prisoners who medical authorities deem in need of special medical attention may be transferred to Federal Bureau of Prisons upon approval by the Office of the Provost Marshal General. HIV infected prisoners within 90 days of release from confinement will normally not be transferred to the Federal Bureau of Prisons.

11–21. Use of force against human immunodeficiency virus infected prisoners

In those circumstances requiring the application of force against an HIV infected prisoner, the force will be applied in a manner consistent with that for force applied to other prisoners.

11–22. Protection of staff

Army Corrections System facility staff should have protective clothing and equipment available to them when there is potential for exposure to the blood or body fluids of any prisoner. One-way airways should be used for all cardiopulmonary resuscitation situations. Additionally, the following protective items should be immediately accessible: impermeable disposable gloves, heavy gloves, coveralls, overshoes or plastic bags to cover shoes, sealable plastic bags, and cleaning solution (household bleach).

11–23. Counseling

a. HIV infected prisoners will be briefed and counseled per paragraphs 4–8 and 4–9. The commander's copy of the counseling should not be kept in the correctional treatment files but, rather, in a separate file. Access to this file will be

limited to use as determined by the installation commander and will be handled per the guidance in paragraph 4–9. Any Family members of HIV infected prisoners who are HCBs will also be counseled per chapter 8.

b. Prior to release from confinement, HIV infected prisoners will again be counseled. During this session, they will be asked if there is any physician to whom a copy of their medical records can be sent to ensure appropriate continuity of health care. After discharge, the Army will honor a request for medical records when properly submitted per AR 40–66.

11–24. Training

Each Army Corrections System facility confinement or correctional facility will have a comprehensive education and training program for all prisoners and staff. This training and education will be conducted per chapter 10 and may be tailored to accommodate concerns of HIV transmission in a confinement or correctional setting.

11–25. Requests for information

Release of HIV infected prisoner population statistics for the U.S. Disciplinary Barracks and regional correctional facilities will be included in statistical data for the installation releasable under existing DOD and DA policy. However, these statistics will not be identified with the confinement or correctional facility; they will merely be included in installation totals. Any request for prisoner population data and statistics will be forwarded to Headquarters, Department of the Army (DAPM–ACC), U.S. Army Corrections Command, 150 Army Pentagon, Washington, DC 20310–0150.

Appendix A
References

Section I
Required Publications

AR 25–55
The Department of the Army Freedom of Information Act Program (Cited in paras 1–5*h*, 1–16*r*(2).)

AR 40–66
Medical Record Administration and Health Care Documentation (Cited in paras 4–13*c*, 8–10*f*(2), 9–2*c*, 11–23*b*.)

AR 40–68
Clinical Quality Management (Cited in paras 6–7*b*, 8–9*d*.)

AR 40–501
Standards of Medical Fitness (Cited in paras 1–16*k*, 2–2*b*(8), 4–110*b*, 4–11*e*(3), 5–3*g*, 6–3*e*, 6–6*a*, 6–14*a*, 6–15*a*, 7–13*a*, 7–13b.)

AR 135–175
Separation of Officers (Cited in paras 7–12*a*, 7–13*b*.)

AR 135–178
Enlisted Administrative Separations (Cited in paras 7–12*a*, 7–13*b*.)

AR 140–10
Assignments, Attachments, Details, and Transfers (Cited in para 7–12*d*.)

AR 140–50
Officer Candidate School, Army Reserve (Cited in para 5–3*h*(3).)

AR 190–47
The Army Corrections System (Cited in para 11–18*a*.)

AR 195–5
Evidence Procedures (Cited in para 11–2*h*.)

AR 340–21
The Army Privacy Program (Cited in paras 1–5*h*, 1–16*r*(2), 8–10*f*(2).)

AR 350–51
United States Army Officer Candidate School (Cited in para 5–3*h*(3).)

AR 600–8–24
Officer Transfers and Discharges (Cited in para 6–13.)

AR 601–100
Appointment of Commissioned and Warrant Officers in the Regular Army (Cited in para 5–2*a*(3).)

AR 601–270
Military Entrance Processing Station (MEPS) (Cited in para 5–3*b*.)

AR 601–280
Army Retention Program (Cited in para 6–6*b*.)

AR 608–75
Exceptional Family Member Program (Cited in para 8–7.)

AR 614–30
Overseas Service (Cited in paras 1–16*f*, 3–2*l*, 6–2*c*, 6–4*b*, 6–8*a*(2), 6–8*a*(3), 6–8*b*(1), 6–11*b*(1).)

AR 614–100
Officers Assignment Policies, Details, and Transfers (Cited in para 6–3*b*(1).)

AR 614–200
Enlisted Assignments and Utilization Management (Cited in para 6–3*b*(1).)

AR 635–40
Physical Evaluation for Retention, Retirement, or Separation (Cited in paras 1–16*k*, 6–8*b*(3), 6–13*g*, 6–14*a*, 6–15*a*.)

AR 635–200
Active Duty Enlisted Administrative Separations (Cited in paras 5–3*h*(3), 6–6*c*(1), 6–6*c*(2), 6–8*d*(2), 6–14.)

DOD 6025.18–R
DOD Health Information Privacy Regulation (Cited in paras 1–5*h*, 1–16*r*(2).)

DODI 6485.01
Human Immunodeficiency Virus (Cited in title page.)

DODI 6490.03
Deployment Health (Cited in para 7–6*b*.)

NGR 351–5
State Military Academies (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.) (Cited in para 5–3*h*(3).)

NGR 600–200
Enlisted Personnel Management (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.) (Cited in para 7–13*a*.)

NGR 635–101
Efficiency and Physical Fitness Boards (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.) (Cited in para 7–13*a*.)

Personnel Policy Guidance
Army G-1 Personnel Policy Guidance (PPG) (Cited in paras 1–16*g*, 7–2*b*.)

PL 110–325
ADA Amendments Act of 2008 (Cited in paras 1–16*q*, 8–10*d*.)

Policy Memorandum, March 29, 2004
Human Immunodeficiency Virus Interval Testing (Available at http://mhs.osd.mil/About_MHS/HA_Policies_Guidelines.aspx.)

5 USC 552
Public information; agency rules, opinions, orders, records, and proceedings (Cited in paras 1–5*h*, 1–16*r*(2).)

10 USC Chapter 61
Retirement or Separation for Physical Disability (Cited in paras 6–13*b*, 6–14*a*(1), 7–1.)

29 USC 701
Findings; purpose; policy (Cited in paras 1–16*q*, 8–10*d*.)

32 USC
National Guard (Cited in para 7–1.)

42 USC 12101
Findings and purpose (Cited in paras 1–16*q*, 8–10*d*.)

Section II
Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

AR 5–9
Area Support Responsibilities

AR 40–5
Preventive Medicine

AR 40–400
Patient Administration

AR 135–18
The Active Guard Reserve (AGR) Program

AR 135–133
Ready Reserve Screening, Qualification Records System, and Change of Address Reports

AR 135–200
Active Duty for Missions, Projects, and Training for Reserve Component Soldiers

AR 600–8–4
Line of Duty Policy, Procedures, and Investigations

AR 600–63
Army Health Promotion

AR 600–85
Army Substance Abuse Program (ASAP)

AR 601–210
Active and Reserve Components Enlistment Program

AR 608–10
Child Development Services

DODI 6130.03
Medical Standards for Appointment, Enlistment, or Induction in the Military Service (Available at http://www.dtic.mil/whs/directives/index.html.)

BPL 09–01
DOD Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Using Licensed Nucleic Acid Tests (NAT) With Approved Mini-Pool Strategies (Available at http://www.militaryblood.dod.mil/Staff/bpl.aspx.)

BPL 10–01
Department of Defense (DOD) Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Updated Multiplex HIV/HCV/HBV Nucleic Acid Testing Algorithm (Available at http://www.militaryblood.dod.mil/Staff/bpl.aspx.)

NGR 40–3
Medical Care for Army National Guard Members (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.)

NGR 635–100
Termination of Appointment and Withdrawal of Federal Recognition (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.)

PL 104–191
Health Insurance Portability and Accountability Act of 1996

Policy Memorandum, March 19, 2010
Policy on the Use of Non-U.S. Food and Drug Administration Compliant Blood Products

Recommendations for Preventing Transmission of Infection with Human T–Lymphotropic Virus Type III/ Lymphadenopathy–Associated Virus in the Workplace, dated Novemver 15, 1985
(Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/00033093.htm.)

Section III
Prescribed Forms

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site (http://www.apd.army.mil).

DA Form 5669
Preventive Medicine Counseling Record (Prescribed in paras 1–14*h*, 2–2, 4–4*e*, 4–5*b*(8) and (9), 4–8, 4–9, 7–9*e*(4), 7–10*c* and *h*, 8–5*a*, B–4*g*.)

DA Form 7303
Donor/Recipient History Interview Form (Prescribed in paras 2–2*b*(17) and (19), 4–5*b*(5), B–4*g*.)

Section IV
Referenced Forms

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site (http://www.apd.army.mil); DD forms are available on the Office of the Secretary of Defense (OSD) Web site (http://www.dtic.mil/whs/directives/infomtg/forms/formsprogram.htm); and Standard Forms (SF) are available on the U.S. General Services Administration (GSA) Web site (http://www.gsa.gov).

DA Form 11–2
Internal Control Evaluation Certification

DA Form 67–9
Officer Evaluation Report

DA Form 2028
Recommended Changes to Publications and Blank Forms

DA Form 2166–8
NCO Evaluation Report

DA Form 3349
Physical Profile

DA Form 4187
Personnel Action

DA Form 4856
Developmental Counseling Form

DD Form 2808
Report of Medical Examination

SF 600
Medical Record - Chronological Record of Medical Care

Appendix B
Internal Control Evaluation

B–1. Function

The function covered by this evaluation is the Identification, Surveillance, and Administration of Personnel Infected with HIV Program.

B–2. Purpose

The purpose of this evaluation is to assist assessable unit managers and internal control administrators in evaluating key internal controls. It is not intended to cover all controls.

B–3. Instructions

These key internal controls must be formally evaluated at least once every 5 years or whenever the internal control administrator changes. Certification that this evaluation has been conducted must be accomplished on DA Form 11–2 (Internal Control Evaluation Certification). Evaluation test questions are outlined in paragraph B–4, below, and are intended as a starting point for each applicable level of internal control evaluation. Answers must be based on the actual testing of key internal controls (for example, document analysis, direct observation, sampling, simulation, other). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation.

B–4. Test questions

a. Are all files kept locked in appropriate containers with access by only those with a need to know?

b. Is there a method in place to ensure Soldiers covered by this regulation are not placed on orders for overseas (for example, TDY or PCS) assignments?

c. Is there a policy and/or plan established and maintained to describe how key internal controls will be evaluated over a 5-year period?

d. Is the commander informed by the HIV program coordinator if his or her Soldier is identified as HIV infected within 4 days?

e. Is there verification of a completed epidemiological assessment or public health department referral for HCBs with a new HIV infection?

f. Are local public health reporting requirements completed for all new diagnosed HIV infections and when a Soldier is in-processing into a new catchment area?

g. Does the duplicate file kept by the HIV program coordinator for Soldiers contain copies of current DA Form 5669, DA Form 4856, DA Form 7303, public health report, and demographics?

h. Is there verification that the AD Soldier is attending infectious disease medical evaluation visits every 6 months and following the medical management plan of his or her physician?

i. Is there verification that the ARNG and Reserve Soldier has completed a FFD physical?

j. Is the commander informed if the Soldier is out of compliance?

k. Does MEDPROS confirm nondeployable status and is there a current PHA?

l. Is HIPAA training current for medical, administrative, and unit staff who, in the performance of their duties, "need to know" a Soldier's HIV positive status?

m. Have all placement personnel been familiarized with the parameters of AR 600–110 relative to military and civilian school assignments?

B–5. Supersession

This evaluation is new and does not replace a previous evaluation.

B–6. Comments

Help to make this a better tool for evaluating internal controls. Submit comments to Deputy Chief of Staff, G–1 (DAPE–HR), 300 Army Pentagon, Washington, DC 20310–0300.

Glossary

Section I
Abbreviations

AC
active component

ACOM
Army command

AD
active duty

ADOS
active duty for operational support

ADT
active duty for training

AGR
Active Guard Reserve

AI
assignment instructions

AIDS
Acquired Immune Deficiency Syndrome

AMEDD
Army Medical Department

AMHRR
Army Military Human Resource Record

AR
Army regulation

ARNG
Army National Guard

ASAP
Alcohol Substance Abuse Program

ASCC
Army service component command

AT
annual training

BPL
Blood Program Letters

CDC
Centers for Disease Control and Prevention

CG
commanding general

COCOM
combatant command

CONUS
continental United States

CPAC
civilian personnel advisory center

DA
Department of the Army

DCS
Deputy Chief of Staff

DD
Department of Defense (forms)

DOD
Department of Defense

DODD
Department of Defense directive

DODI
Department of Defense instruction

DRU
direct reporting unit

EFMP
Exceptional Family Member Program

FDA
Food and Drug Administration

FOIA
Freedom of Information Act

FOUO
for official use only

FST
foreign service tour

FTNGD
full-time National Guard duty

GSA
General Services Administration

HIPAA
Health Insurance Portability and Accountability Act

HIV
human immunodeficiency virus

HQDA
Headquarters, Department of the Army

HRC
Human Resources Command

IMA
individual mobilization augmentee

IRR
individual ready reserve

JAGC
Judge Advocate General's Corps

MEDCEN
medical center

MEDDAC
medical department activity

MEDPROS
Medical Protection System

MEPS
military entrance processing station

MOS
military occupational specialty

MTF
medical treatment facility

NGB
National Guard Bureau

NGR
National Guard regulation

OCAR
Office of the Chief, Army Reserve

OCONUS
outside the continental United States

OCS
Officer Candidate School

OTSG
Office of The Surgeon General

PCS
permanent change of station

PHA
periodic health assessment

PHN
public health nurse

PL
public law

POC
point of contact

PULHES
physical, upper, lower, hearing, eyes, psychiatric

RC
reserve component

REFRAD
release from active duty

ROTC
Reserve Officer Training Corps

SF
standard form

STD
sexually transmitted disease

TDA
table of distribution and allowances

TDY
temporary duty

TPU
troop program unit

U.S.
United States

UCMJ
Uniform Code of Military Justice

USAMEDCOM
U.S. Army Medical Command

USAPHC
U.S. Army Public Health Command

USAR
U.S. Army Reserve

USARC
U.S. Army Reserve Command

USC
United States Code

USMA
U.S. Military Academy

Section II
Terms

ADOS
The Active Duty Operational Support-Reserve Component Program is an authorized tour of active duty performed pursuant to 10 USC 12301(d) and it includes: active duty for training performed at the request of an organizational or operational commander; active duty or ADT performed as a result of reimbursable funding; funeral honors duty performed not in an inactive duty status; and active duty performed by members of the Retired Reserve not receiving regular retired pay. Most tours are only 14 days in length but can go to 2 years depending upon the position filled and additional military requirements. This term replaced extended active duty (EAD) and temporary tour of active duty

(TTAD). The term contingency ADOS (CO-ADOS) replaced voluntary active duty formerly known as contingency EAD (CO-EAD) and contingency TTAD (CO-TTAD). The term ADOS Reserve Component (ADOS-RC) replaced RC-funded, voluntary active duty formerly known as active duty for special work (ADSW).

Biennial
Every 2 years.

Catchment area
Area and population from which an MTF gets its patients/enrollees.

Enzyme linked immunosorbent assay
A commonly used screening test to detect antibodies to HIV.

Designated medical treatment facility
Servicing medical treatment facility.

Epidemiological assessment
Medical evaluation process used by medical personnel/HIV PHN to determine possible sources of exposure to HIV.

Exudative
A discharge of certain elements of the blood into the tissues.

Health care beneficiary
A person who, because of military status, employment, or by legal relationship to a person so entitled, is eligible to receive medical care in military medical treatment facilities.

Human immunodeficiency virus infected
An individual who has been confirmed to be infected with HIV by a positive HIV screening test and at least two separate confirmatory tests.

Human immunodeficiency virus negative
A screening specimen that was not reactive or, if reactive, has been determined not to have HIV antibodies or virus present after confirmatory testing.

Immunological deficiency
Persistent reduction in the level of T-helper lymphocytes below 300 cells per cubic millimeter for greater than one month without other demonstrable cause; reduced or absent delayed hypersensitivity, as measured by the standardized battery of skin tests (in association with other significant clinical findings); development of thrush; increased susceptibility to either common or uncommon infections; and more severe episodes of infection than usually seen with a given organism.

Initial test cycle
A series of HIV tests which includes an initial screening test at a minimum. If the initial test is reactive (positive), the test cycle includes duplicate initial testing and confirmatory tests necessary to determine an individual's HIV status.

Longitudinal
A study conducted from initial diagnosis through termination of the condition.

Major installation
Any installation with a military population of 5000 or more.

Overseas
Outside the 50 States of the United States, the District of Columbia, and Puerto Rico.

Progressive clinical illness
Development of neurological manifestations; Kaposi's sarcoma; other lymphoreticular malignancies; thrombocytopenia; diffuse, persistent lymphadenopathy; or unexplained weight loss, diarrhea, anorexia, fever, malaise, or fatigue.

Reflex
Testing performed when an initial test result is outside of the expected normal range (for example, result is reactive and thus a second test(s) is medically indicated). The primary or initial test result is enhanced by the second test(s) as it

provides diagnostic, prognostic, and/or therapeutic information. (This process is done automatically in order to clarify results.)

Unit commander
Company, troop, battery, or detachment commander.

Western Blot
Laboratory test that detects specific antibodies to components of a virus. Chiefly used to confirm HIV antibodies in specimens found repeatedly reactive using enzyme linked immunosobent assay.

Section III
Special Abbreviations and Terms

DNA
deoxyribo nucleic acid

FFD
fit for duty

HBV
hepatitis B virus

HCB
health care beneficiary

HCV
hepatitis C virus

NAT
nucleic acid test

STI
sexually transmitted infection

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EXHIBIT 5

Department of Defense

INSTRUCTION

NUMBER 6490.07
February 5, 2010

USD(P&R)

SUBJECT: Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)) and the guidance in DoDDs 6200.04 and 1400.31 (References (b) and (c)), this Instruction establishes policy, assigns responsibilities, and provides procedures for ensuring that Service members and DoD civilian employees, including Coast Guard Service members and civilian employees at all times, including when the Coast Guard is a Service in the Department of Homeland Security by agreement with that Department, (hereafter referred to collectively as "DoD personnel") deployed and deploying on contingency deployments are medically able to accomplish their duties in deployed environments.

2. APPLICABILITY. This Instruction:

a. 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 Department of Defense (hereafter referred to collectively as the "DoD Components").

(2) DoD personnel deployed and deploying on contingency deployments consistent with DoD and Service-specific guidance, including Reference (c) and DoD Instruction (DoDI) 1400.32 (Reference (d)).

b. Does not apply to contingency contractor personnel, who shall comply with the guidance in DoDI 3020.41 (Reference (e)), or to shipboard operations that are not anticipated to involve operations ashore, which shall follow Service-specific guidance.

c. Shall be used as a minimum medical standard for all deploying and deployed DoD personnel, BUT does not alter or replace:

(1) With respect to military personnel, the accession, retention, and general fitness for duty standards previously established by the Department of Defense, including those described in DoDI 6130.4, DoDD 6130.3, Under Secretary of Defense for Personnel and Readiness (USD(P&R)) Memorandum, Assistant Secretary of Defense for Health Affairs (ASD(HA)) Memorandum, and DoDI 6485.01 (References (f) through (j), respectively).

(2) With respect to civilian employees covered by sections 791 and 794a of title 29, United States Code (also known and hereafter referred to as "The Rehabilitation Act of 1973, as amended" (Reference (k))), the legal obligations of a DoD Component as an employer pursuant to that Act.

(3) More stringent individual Military Department policy guidance or Service-specific readiness requirements.

3. DEFINITIONS. These terms and their definitions are for the purpose of this Instruction.

a. contingency. A situation requiring military operations in response to natural disasters, terrorists, subversives, or as otherwise directed by appropriate authority to protect US interests.

b. contingency deployment. A deployment that is limited to outside the continental United States, over 30 days in duration, and in a location with medical support from only non-fixed (temporary) military medical treatment facilities. It is a deployment in which the relocation of forces and materiel is to an operational area in which a contingency is or may be occurring.

c. deployment. The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intra-continental United States, inter-theater, and intra-theater movement legs, staging, and holding areas.

d. medical assessment. The total of the pre-deployment activities described in section 1 of Enclosure 2 of this Instruction and those listed in paragraph E4.A1.1 of DoDI 6490.03 (Reference (l)).

e. trained DoD health-care provider. A physician, physician assistant, nurse practitioner, advanced practice nurse, independent duty corpsman, independent duty medical technician, or special forces medical sergeant.

4. POLICY. It is DoD policy that:

a. The medical standards in this Instruction are mandatory for contingency deployments, and permissible for any other deployment, based on the commander's decision.

b. DoD personnel with existing medical conditions may deploy based upon a medical assessment as described in Enclosure 2 and subparagraph E4.A1.1.1. of Reference (l), which for civilian employees shall be consistent with subparagraph 4.g.(3)(c) of DoDD 1404.10 (Reference (m)), and the requirements of The Rehabilitation Act of 1973, as amended, when such civilian employees are covered by that Act, if all of these 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) 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. 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.

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

(5) In the case of civilian employees covered by The Rehabilitation Act of 1973, as amended, it is determined, based upon an individualized assessment, that the employee 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 employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

c. Individuals with the conditions in Enclosure 3, based on medical assessments in accordance with Enclosure 2 and Reference (l), shall not deploy unless a waiver can be granted according to the procedures in section 3 of Enclosure 2.

d. If a Service member is found qualified for retention with no limitations on assignments or deployments following evaluation of a medical condition by competent medical and personnel authority of his or her respective Service, and if the condition remains stable, a deployment waiver of that same condition is not required by this Instruction.

e. Deploying commanders may add additional medical requirements to the standards in this Instruction based upon the demands of a specific deployment. Commanders may apply these medical standards to other deployments based on the health risk, physical demands, and medical

capabilities of the deployment. These additional standards must be consistent with The Rehabilitation Act of 1973, as amended, when applied to civilian employees covered by that Act.

f. Protected health information collected, used, and released in the execution of this Instruction shall be protected as required by DoD 6025.18-R (Reference (n)) and DoD 8580.02-R (Reference (o)).

5. RESPONSIBILITIES. See Enclosure 4.

6. PROCEDURES. See Enclosure 2.

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

8. EFFECTIVE DATE. This Instruction is effective immediately.

Gail H. McGinn
Deputy Under Secretary of Defense (Plans)
Performing the Duties of the
Under Secretary of Defense for
Personnel and Readiness

Enclosures:
1. References
2. Procedures
3. Medical Conditions Usually Precluding Contingency Deployment
4. Responsibilities

TABLE OF CONTENTS

ENCLOSURE 1

REFERENCES

(a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(b) DoD Directive 6200.04, "Force Health Protection (FHP)," October 9, 2004
(c) DoD Directive 1400.31, "DoD Civilian Work Force Contingency and Emergency Planning and Execution," April 28, 1995
(d) DoD Instruction 1400.32, "DoD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures," April 24, 1995
(e) DoD Instruction 3020.41, "Contractor Personnel Authorized to Accompany the U.S. Armed Forces," October 3, 2005
(f) DoD Instruction 6130.4, "Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces," January 18, 2005
(g) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, and Induction," December 15, 2000
(h) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy Guidance for Medical Deferral," February 9, 2006
(i) Assistant Secretary of Defense for Health Affairs Memorandum, "Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications," November 7, 2006
(j) DoD Instruction 6485.01, "Human Immunodeficiency Virus," October 17, 2006
(k) Sections 791 and 794a of title 29, United States Code (also known as "The Rehabilitation Act of 1973, as amended")
(l) DoD Instruction 6490.03, "Deployment Health," August 11, 2006
(m) DoD Directive 1404.10, "DoD Civilian Expeditionary Workforce," January 23, 2009
(n) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
(o) DoD 8580.02-R, "DoD Health Information Security Regulation," July 12, 2007

ENCLOSURE 2

PROCEDURES

1. PERFORMANCE OF MEDICAL ASSESSMENTS. All DoD personnel serving in a contingency deployment as defined in section 3 of the front matter of this Instruction must undergo a medical assessment prior to deployment in accordance with subparagraph E4.A1.1.1. of Reference (l). The mandatory portions of the assessment are:

a. Completion of DD Forms 2795, "Pre-Deployment Health Assessment," and 2766, "Adult Preventive and Chronic Care Flowsheet" (available on the Internet at http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm). Except for Coast Guard personnel, completed copies of both of these forms must be submitted to the Defense Medical Surveillance System and included in DoD personnel deployment paperwork, and shall serve as the deployment medical record. For Coast Guard personnel, the DD Form 2766 shall be placed in the member's health record, but all other procedures for Coast Guard personnel shall be as described in this Instruction for DoD personnel.

b. Medical record review.

c. Current periodic health assessment (Service members only).

d. Physical exam within 1 year of deployment (DoD civilian employees only).

2. DETERMINATIONS OF DEPLOYABILITY. A trained DoD health-care provider must make a provisional determination on DD Form 2795 as to the deployability of DoD personnel. This decision should be based on all of the information obtained in the medical assessment described in section 1 of this enclosure.

a. In general, DoD personnel with any of the medical conditions in Enclosure 3, and based on a medical assessment, shall not deploy unless a waiver is granted. Consideration should be made for the nature of the disability and if it would put the individual at increased risk of injury or illness, or if the condition is likely to significantly worsen in the deployed environment.

(1) For civilian employees covered by The Rehabilitation Act of 1973, as amended, it must be determined, before deployment and based upon an individualized assessment, that the employee 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 employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

(2) The requirement to provide reasonable accommodations for disabilities does not apply to deployment of military members, nor to civilian employees not covered by The Rehabilitation Act of 1973, as amended.

b. All individuals deemed not deployable at the deployment processing center shall be returned to their originating unit with a DD Form 2795 and a summary of their non-deployable medical condition to provide to the unit medical personnel. The civilian supervisor shall also be notified if the individual is deemed not deployable.

3. WAIVERS. If a commander or supervisor of DoD personnel (except for SOF personnel) wishes to deploy an individual with a medical condition that could be disqualifying (see Enclosure 3, the commander or supervisor must request a waiver. The waiver request shall be submitted to the applicable Combatant Commander through the individual's servicing military medical unit in the case of a Service member, or through the individual's personnel office in the case of a civilian employee, with medical input provided by the individual's medical provider.

a. Requests for a waiver shall include a summary of a detailed medical evaluation or consultation concerning the medical condition(s). Maximization of mission accomplishment and the protection of the health of personnel are the ultimate goals. Justification shall include statements indicating service experience, position to be placed in, any known specific hazards of the position, anticipated availability and need for care while deployed, the benefit expected to accrue from the waiver, the recommendation of the commander or supervisor, and the reasonable accommodations that can be provided for civilian employees covered by The Rehabilitation Act of 1973, as amended. For all DoD personnel, the factors listed in subparagraphs 4.b.(1) through 4.b.(4), (and subparagraph 4.b.(5) for civilian employees only) of the front matter shall be discussed.

b. For SOF personnel with any of the conditions listed in Enclosure 3, medical clearance may be granted by the CDRUSSOCOM, subject to the approval of the Combatant Commander under which the Service member is deployed or will deploy.

c. In the case of civilian employees covered by The Rehabilitation Act of 1973, as amended, a waiver must be granted if it is determined, based upon an individualized assessment, that the employee 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 employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

4. ROLES AND RESPONSIBILITIES

a. Commanders and Supervisors. Commanders and supervisors shall:

(1) Ensure deploying DoD personnel are appropriately assessed by competent medical authority before deployment, in accordance with Reference (l).

(2) Request waivers for DoD personnel they wish to deploy who have the medical conditions described in Enclosure 3.

(3) Ensure that DoD personnel under their command meet the medical standards of the gaining commander when individuals and their leaders deploy in support of other DoD Components. As these standards may differ by assignment, they must be coordinated separately for each deployment.

b. Supervisors. Supervisors shall additionally:

(1) Identify medical and physical requirements for deployable positions designated for fill by DoD civilian employees.

(2) Ensure that such requirements are documented in position descriptions, vacancy announcements, and other appropriate sources.

(3) Ensure that DoD civilian employees meet such requirements; take appropriate action when employees no longer meet identified requirements.

c. DoD Personnel

(1) DoD personnel in deployable positions shall be responsible for meeting the medical and physical requirements of their deployment-specific tasks.

(2) DoD personnel who are civilian employees selected for deployment opportunities outside their chain of supervision shall be responsible for meeting and maintaining the medical standards identified for the deployment by the responsible commanding officer.

ENCLOSURE 3

MEDICAL CONDITIONS USUALLY PRECLUDING CONTINGENCY DEPLOYMENT

This list of conditions is not intended to be all-inclusive. A list of all possible diagnoses and their severity that may cause an individual to be potentially non-deployable, pending further evaluation, would be too extensive. Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. In general, individuals with the conditions in paragraphs a. through h. of this enclosure, based upon a medical assessment as described in Enclosure 2 and Reference (l), shall not deploy unless a waiver is granted.

a. Conditions Affecting Force Health Protection

(1) Physical or psychological conditions resulting in the inability to effectively wear personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical and/or biological protective garments, regardless of the nature of the condition that causes the inability to wear the equipment if wearing such equipment may be reasonably anticipated or required in the deployed location.

(2) Conditions that prohibit immunizations or the use of force health protection prescription products (FHPPPs) required for the specific deployment. Depending on the applicable threat assessment, required FHPPPs may include atropine, epinephrine, and/or pralidoxime chloride (2-PAM chloride) auto-injectors; certain antimicrobials and antimalarials; and pyridostigmine bromide.

b. Unresolved Health Conditions Requiring Care or Affecting Performance

(1) Any chronic medical condition that requires frequent clinical visits, fails to respond to adequate conservative treatment, or necessitates significant limitation of physical activity.

(2) Absence of a dental exam within the last 12 months or presence of the likelihood that dental treatment or reevaluation for oral conditions will result in dental emergencies within 12 months. Individuals being evaluated by a non-DoD civilian dentist should use DD Form 2813, "DoD Active Duty/Reserve Forces Dental Examination," as proof of dental examination (available on the Internet at http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm).

(3) Pregnancy.

(4) Any medical condition that requires either durable medical equipment or appliances, or periodic evaluation or treatment by medical specialists that is not readily available in theater.

(5) Any unresolved acute or chronic illness or injury that would impair duty performance in a deployed environment during the duration of the deployment.

(6) Cancer that requires continuing treatment or specialty medical evaluations during the anticipated duration of the deployment.

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

(8) Any medical condition that requires surgery or for which surgery has been performed that requires rehabilitation or additional surgery to remove devices.

(9) Any musculoskeletal condition that significantly impairs performance of duties in a deployed environment.

(10) An acute exacerbation of a physical or mental health condition that could significantly affect duty performance.

c. Conditions That Could Cause Sudden Incapacitation

(1) Recurrent loss of consciousness for any reason.

(2) Any medical condition that could result in sudden incapacitation including a history of stroke within the last 24 months, seizure disorders, and diabetes mellitus type I or II treated with insulin or oral hypoglycemic agents.

d. Pulmonary Disorders. Asthma that has a forced expiratory volume-1 (FEV-1) of less than or equal to 60 percent of predicted FEV-1 despite appropriate therapy and that has required hospitalization at least 2 times in the last 12 months, or that requires daily systemic (not inhalational) steroids.

e. Infectious Disease

(1) Active tuberculosis or known blood-borne diseases that may be transmitted to others in a deployed environment.

(2) A diagnosis of human immunodeficiency (HIV) antibody positive with the presence of progressive clinical illness or immunological deficiency. The cognizant Combatant Command surgeon shall be consulted in all instances of HIV seropositivity before medical clearance for deployment.

f. Sensory Disorders

(1) Hearing Loss. The requirement for use of a hearing aid does not necessarily preclude deployment. However, the individual must have sufficient unaided hearing to perform duties safely.

(2) Vision Loss. Best corrected visual acuity must meet job requirements to perform duties safely.

g. Cardiac and Vascular Disorders

(1) Hypertension not controlled with medication or that requires frequent monitoring.

(2) Symptomatic coronary artery disease.

(3) History of myocardial infarction within 1 year of deployment.

(4) History of coronary artery bypass graft, coronary artery angioplasty, carotid endarterectomy, other arterial stenting, or aneurysm repair within 1 year of deployment.

(5) Cardiac dysrhythmias or arrhythmias, either symptomatic or requiring medical or electrophysiologic control (presence of an implanted defibrillator and/or pacemaker).

(6) Heart failure.

h. Mental Health Disorders

(1) Psychotic and/or bipolar disorders. (See Reference (i) for detailed guidance on deployment-limiting psychiatric conditions or psychotropic medications.)

(2) Psychiatric disorders under treatment with fewer than 3 months of demonstrated stability.

(3) Clinical psychiatric disorders with residual symptoms that impair duty performance.

(4) Mental health conditions that pose a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment.

(5) Chronic medical conditions that require ongoing treatment with antipsychotics, lithium, or anticonvulsants.

ENCLOSURE 4

RESPONSIBILITIES

1. ASD(HA). The ASD(HA), under the authority, direction, and control of the USD(P&R), shall review and issue to the Secretaries of the Military Departments and the Directors of the Defense Agencies and the DoD Field Activities technical adjustments to the deployment standards in Enclosure 3 as needed, based on changing conditions or additional unanticipated difficulties encountered in the in-theater management of medical conditions.

2. SECRETARIES OF THE MILITARY DEPARTMENTS, COMMANDANT OF THE COAST GUARD, AND DIRECTORS OF THE DEFENSE AGENCIES AND THE DoD FIELD ACTIVITIES. The Secretaries of the Military Departments, the Commandant of the Coast Guard, and the Directors of the Defense Agencies and the DoD Field Activities shall:

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

b. Ensure that:

(1) All deploying DoD personnel assigned to their respective Service, Defense Agency, or DoD Field Activity have a medical assessment in accordance with Reference (l), including a medical record review, to evaluate their medical status before contingency deployments and other deployments pursuant to paragraph 4.a. of the front matter of this Instruction.

(2) Pre-deployment processes are in place to identify individuals with deployment-limiting medical conditions.

(3) DoD personnel who occupy deployable positions maintain a high state of pre-deployment health and medical readiness.

3. CHAIRMAN OF THE JOINT CHIEFS OF STAFF. The Chairman of the Joint Chiefs of Staff shall ensure that the Combatant Commanders:

a. Establish a minimum standard when developing medical requirements for entering the theater of operations that factors in the medical conditions described in Enclosure 3 of this Instruction.

b. Implement a medical requirements waiver process that includes waiver computerization and archival storage.

4. COMBATANT COMMANDERS. For all DoD personnel deployed or deploying to a theater within their respective Combatant Commands, the Combatant Commanders shall:

a. Establish a process for reviewing recommendations from the Services regarding the granting of exceptions to medical standards (waivers) for the conditions in Enclosure 3, including a mechanism to track and archive all approved or denied waivers and the medical conditions requiring the waivers.

b. Serve as the final approval authority for exceptions to the medical standards (waivers) made pursuant to the procedures in this Instruction.

5. COMMANDER, UNITED STATES SPECIAL OPERATIONS COMMAND (CDRUSSOCOM). The CDRUSSOCOM shall perform the responsibilities in section 2 of this enclosure for SOF personnel.

EXHIBIT 6

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//
AMPN/DODD 1404.10/DOD CIVILIAN EXPEDITIONARY WORKFORCE//

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//

REF/W/DOC/ASD(HA)/12DEC2015//
AMPN/DODI 5154.30/ARMED FORCES INSTITUTE OF PATHOLOGY OPERATIONS//

REF/X/DOC/ASD(HA)/20APR2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/GUIDELINE FOR TUBERCULOSIS SCREENING AND TESTING//

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//

REF/BB/USD(I)/20MAR2009, AS AMENDED 02SEP2014//
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//

REF//FF/DOC/J4/02NOV2007//
AMPN/MCM-0028-07/PROCEDURES FOR DEPLOYMENT HEALTH SURVEILLANCE//

REF/GG/DOC/CC/08MAR2016//
AMPN/CCR 40-2/DEPLOYMENT FORCE HEALTH PROTECTION//

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//