UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

NICHOLAS HARRISON, et al., Plaintiffs, v. LLOYD J. AUSTIN, Secretary of Defense, et al., Defendants.	Civil Action No. 1:18-cv-641 (LMB/IDD)
RICHARD ROE, et al., Plaintiffs, v. LLOYD J. AUSTIN, Secretary of Defense, et al., Defendants.	Civil Action No. 1:18-cv-1565 (LMB/IDD)

MEMORANDUM IN SUPPORT OF PLAINTIFF RICHARD ROE AND MODERN MILITARY ASSOCIATION OF AMERICA'S MOTION TO ENFORCE THE ORDERS DATED APRIL 6, 2022 (AS AMENDED MAY 10, 2022) AND FOR AN ORDER TO SHOW CAUSE WHY DEFENDANTS SHOULD NOT BE HELD IN CONTEMPT

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I. INTRODUCTION

Plaintiffs Modern Military Association of America ("MMAA") and Richard Roe (together, "Movants") bring this Motion to Enforce the Orders of the Court dated April 6, 2022 (as amended May 10, 2022) and for an Order to Show Cause Why Defendants Should Not Be Held in Contempt. The changes Defendants made to their policies and regulations have not resulted in compliance with the permanent injunctions issued in this case, which prohibit them from applying the categorical bar based on HIV status to service members living with HIV who are asymptomatic and have an undetectable viral load.[1] Defendants have left in place almost all of the roadblocks that existed previously, which has had the inevitable effect of denying to healthy and qualified service members opportunities they otherwise would have had enjoyed.

After first reviewing the changes announced by Defendants on June 6, 2022, Plaintiffs' counsel was skeptical they would result in compliance with the Court's injunctions but decided to allow time and experience to reveal their actual effect. Unfortunately, counsel's skepticism was borne out, as multiple HIV-positive service members, including Movant Richard Roe, have continued to encounter barriers to obtaining authorization for deployment, competing for preferred assignments, taking advantage of educational and training opportunities, and securing a commission.

[1] An HIV-positive person with a suppressed or undetectable viral load will not have any symptoms directly traceable to HIV. The appearance of HIV-related symptoms in a person with untreated chronic HIV infection signals that the person is moving from the second or "asymptomatic" stage of the disease into the third stage, commonly known as AIDS. *The Stages of HIV Infection*, https://hivinfo.nih.gov/understanding-hiv/fact-sheets/stages-hiv-infection (last reviewed Aug. 20, 2021); *Symptoms of HIV,* https://www.hiv.gov/hiv-basics/overview/about-hiv-and-aids/symptoms-of-hiv/ (updated June 15, 2022). People receiving effective treatment for HIV, however, do not develop HIV-related symptoms, making the label "asymptomatic" redundant to a suppressed or undetectable viral load. *Id.* This redundancy—along with the significant decline in use of "asymptomatic" to describe the second stage of HIV infection since publication of the military standards employing the term—has led to some confusion for physicians being asked to evaluate service members living with HIV in support of waiver applications under the revised regulations.

Movants submit that the only reasonable construction of the Court's orders is that they placed Plaintiffs Richard Roe, Victor Voe, Nick Harrison, and all other asymptomatic HIV-positive service members with an undetectable viral load (hereinafter, "AHPSMUVL") in the same position as service members with other chronic conditions that do not affect deployability if defined health metrics applicable to the condition are met. That is, AHPSMUVL should be considered presumptively deployable and should no longer be required to obtain a medical waiver—an onerous process placing them at a substantial disadvantage—before being cleared for a contingency deployment. But Defendants' policy and regulatory changes did not eliminate the medical waiver requirement for AHPSMUVL, a step that would make them presumptively deployable like service members with other chronic conditions that do not affect deployability. Instead, because the waiver requirement was maintained, military commanders retain much of the same discretion they previously had to deny deployments and commissions to AHPSMUVL.

To effectuate its orders and the victory Plaintiffs secured on summary judgment, the Court will need to take further action to modify the conduct of Defendants. Because Defendants are not in compliance with this Court's injunctions and continue to engage in violations of the equal protection components of the Constitution and the Administrative Procedures Act ("APA"), Movants respectfully request that the Court enforce its injunctions by ordering Defendants to show cause why they should not be held in contempt. Movants' counsel is willing to participate in this process in whatever manner the Court desires and to engage in any further monitoring deemed appropriate.

II. BACKGROUND

A. The Court's orders and Defendants' subsequent policy changes

On April 6, 2022, after granting summary judgment in Plaintiffs' favor (*Harrison v. Austin*, 597 F. Supp. 3d 884 (E.D. Va. 2022)), this Court entered two orders. As later amended, the relevant portions of those orders read:

Roe Order

> [It is] ORDERED, ADJUDGED, and DECREED that defendants be and are ENJOINED from categorically barring the worldwide deployment or deployment to the United States Central Command ("CENTCOM") of plaintiffs Richard Roe, Victor Voe, and any other asymptomatic HIV-positive service members with an undetectable viral load due to their HIV-positive status[.]

Harrison Orders

> [It is] ORDERED, ADJUDGED, and DECREED that defendants be and are ENJOINED from categorically barring the worldwide deployment or deployment to the United States Central Command ("CENTCOM") of plaintiff Nicholas Harrison and any other asymptomatic HIV-positive service member with an undetectable viral load due to their HIV-positive status; and it is further
>
> ORDERED, ADJUDGED, and DECREED that defendants be and are ENJOINED from denying the application of Harrison and any other asymptomatic HIV-positive service member with an undetectable viral load to commission as officers because they are classified as ineligible for worldwide deployment or deployment to CENTCOM due to their HIV-positive status[.]

Amended Order, ECF 328, *Roe v. Austin*, No. 1:18-cv-1565 (LMB/IDD) (E.D. Va. Apr. 6, 2022); Amended Order, ECF 314, *Harrison v. Austin*, No. 1:18-cv-641 (LMB/IDD) (E.D. Va. Apr. 6, 2022).

In response to the injunctions, Defendant Austin issued a memo on June 6, 2022, announcing changes DoD was making to policies and regulations governing service members living with HIV. Perkowski Decl. [Ex. A] ¶ 2.a; *id.* Ex. 1 [Memorandum fr. Lloyd J. Austin re: Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces (June 6, 2022)] ("HIV Memo" or "Memo"). The Memo contains statements that appear to signal

compliance with the Court's injunctions. It also improperly narrows the scope and effect of those orders and attempts to retain discretion to deny deployment and commissions to AHPSMUVL based on their HIV status—discretion that the orders do not contemplate. Most significantly, the HIV Memo leaves AHPSMUVL presumptively non-deployable by failing to eliminate the waiver requirement, which therefore still applies to all service members with HIV. *Id.*

The same day the Memo issued, a DoD Public Relations official conducted a briefing on the changes outlined in the Memo and published a communication plan. Perkowski Decl. [Ex. A] ¶ 2.c & Ex. 5 [Office of the Secretary of Defense Public Affairs, *Communication Plan: Policy Regarding HIV-Positive Personnel Within the Armed Forces* (June 7, 2022)] ("Comm Plan"). In contrast to the Memo itself, the talking points repeatedly state that service members with HIV are *not* required to be deployed, instruct that all such service members are to be evaluated on a "case-by-case" basis—implying a different standard than that which applies to other service members—and send the overall message that little has actually changed with respect to how the military will handle service members living with HIV. *Id*.

B. Application of the policies to current service members

Minimal changes to written regulations are not the only way Defendants' post-judgment activity has fallen short. Defendants' application of their revised policies in real-life situations demonstrates they are treating service members with HIV in a manner largely unchanged.

1. Defendants continue to require all service members with HIV, regardless of viral load, to obtain a medical waiver to deploy or commission.

The military departments place flags or codes on the records of service members to signify that they are subject to restrictions on assignment or deployment—most significantly, the inability to deploy without first securing a medical waiver. Perkowski Decl. ¶¶ 9-22. In the Air Force, it is called an Assignment Limitation Code ("ALC"); in the Army, it's a Medical

Readiness Classification ("MRC"). *Id.* ¶¶ 10-19. The practice of applying them to service members with HIV—regardless of viral load—has not changed since the Court's orders. *Id.* ¶ 9. The codes and their attendant restrictions create impediments and barriers to deployment and commissioning for service members with HIV. For example, these limitation codes are used in determining which members will deploy when a unit is selected to send a quota of members to an overseas contingency location, a process called "deployment tasking:"

> The first thing senior leaders do is pull the Alpha Roster for the unit, which is essentially an Excel spreadsheet with every unit member's information on it. They then filter out anyone that has an assignment limitation code (ALC), an assignment availability code (AAC), a deployment availability code (DAV), or any other code deemed undesirable for deployment, such as an Unfavorable Information File (UIF) or Control Roster designation. The senior leaders then sort the list from longest to shortest "dwell time," which is the number of days since last deployment, and begin calling Airman on the list from top to bottom to discover if there are any other reasons that member would not be able to deploy. If they identify enough eligible Airmen to fulfill the quota on the order that has been sent down, the deployment tasking is complete.

Roe Decl. [Ex. B] ¶ 6. This means AHPSMUVL often will not be selected for deployment solely as a result of the limitation code that Defendants continue to place on their files.

Rather than remove these codes once service members with HIV achieve an undetectable viral load, Defendants continue to subject them to the waiver requirement. That is, every service member with asymptomatic HIV and an undetectable viral load—the very individuals to whom the Court provided relief—must prepare and submit a medical waiver to qualify to deploy or commission (and often to change duty assignment or station). Perkowski Decl. [Ex. A] ¶¶ 9-22.

To apply for a waiver, an individual must first secure the support of their chain of command. Perkowski Decl. [Ex. A], Ex. 6 [DoDI 6490.07, Encl. 2, ¶ 3]. The decision to support or reject such a request is at the commander's complete discretion, with no apparent guidelines for making the decision or requirement to explain it. *Id.* If a service member secures support

from their chain of command, they must assemble materials to support the waiver request for submission to the Combatant Command for the deployment. *Id.* For service members living with HIV, that includes obtaining a letter from their primary care physician confirming that they are "asymptomatic," have an undetectable viral load, and are otherwise medically fit to deploy. *Id.* But there is significantly more: According to DoDI 6490.07, a waiver request for a service member seeking a contingency deployment[2]—the type of deployment for which Plaintiffs fought to secure equal access in this litigation (*Harrison*, 597 F. Supp. 3d at 896)—must include:

> [A] summary of a detailed medical evaluation or consultation concerning the medical condition(s). … 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…. For all DoD personnel, the factors listed in subparagraphs 4.b.(1) through 4.b.(4) … shall be discussed.

Perkowski Decl. [Ex. A], Ex. 6 [DoDI 6490.07, Encl. 2., ¶ 3(a)]. The "factors listed in the subparagraphs 4.b.(1) through 4.b.(4)" will seem familiar because Defendants spent over four years trying to convince this Court that these factors justified contingency deployment disqualification for service members living with HIV:

> (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,

[2] For other types of deployments, application of the standards of DoDI 6490.07 is "permissive" rather than mandatory. Perkowski Decl. [Ex. A], Ex. 6 [DoDI 6490.07 ¶ 4(a)].

> 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.)

Id. [DoDI 6490.07 ¶ 4(b)(1)-(4)]; *Harrison*, 597 F. Supp. 3d at 896 (detailing the same criteria). Despite the Court's rejection of those arguments, HIV *remains* on the list of "Medical Conditions Usually Precluding Contingency Deployment." Perkowski Decl. [Ex. A], Ex. 6 [DoDI 6490.07, Encl. 3, ¶ e.(2)]. The entry for HIV also continues to require that "the cognizant Combatant Command surgeon … be consulted in all instances of HIV seropositivity before medical clearance for deployment," keeping it as the only condition requiring that additional approval before receiving clearance to deploy. *Id.* The waiver burden is not imposed upon service members with other chronic conditions who meet the condition-specific criteria that make them—like service members without a chronic condition—presumptively deployable under DoDI 6490.07. *Id.* [DoDI 6490.07, Encl. 2., ¶ 3(a)].

Delays in processing medical waivers can substantially affect a service member's deployment or even render the granting of a waiver meaningless. In short, deployment of service members with HIV are still governed by the same unchanged regulations and policies that existed when the Court issued its judgment, and medical waivers continue to present a substantial barrier to assignments, deployment, and commissioning for these members.

2. HIV-positive service members continue to face barriers to commissioning, reassignment, and deployment since the Court's orders.

The post-injunction system described above has not brought about significant changes for service members living with HIV, who continue to face substantial barriers to commissioning, deployment, and other opportunities despite being asymptomatic and having an undetectable viral load. As the following stories show, ALCs and MRCs interfere with the mobility of service

members with HIV by requiring them to obtain a waiver. A lack of clarity and transparency, misinformation about HIV, confusion among supervisory personnel, and the resulting inconsistency so plague the waiver process that service members with HIV have been excluded from numerous opportunities. Though not a comprehensive canvassing of recent experiences (*see* Perkowski Decl. ¶¶ 25-72), these stories exemplify Defendants' non-compliance with the Court's orders and the on-going equal protection violations.[3]

Sergeant A.J.: Army Sergeant A.J. serves in a battalion of a state Army National Guard (ARNG) that in the fall of 2022 received orders to deploy to Saudi Arabia. Perkowski Decl. [Ex. A] ¶ 26. Because, like all Soldiers with HIV, his MRC still classifies him as non-deployable, SGT A.J. was forced to obtain a medical waiver to deploy with his unit. *Id.* ¶ 27. After securing the support of his unit command, Sergeant A.J. submitted a waiver request. *Id.* Initially, battalion command and the ARNG waiver authority did not transmit the waiver request because CENTCOM informed them it would not be granted for HIV. *Id.* ¶ 28. After Plaintiffs' counsel intervened, the ARNG waiver authority approved the request and forwarded it to CENTCOM for further approval, in accordance with MOD16 to the USCENTCOM Individual Protection and Individual/Unit Deployment Policy.[4] *Id.* ¶¶ 28-29.

But CENTCOM denied this waiver request. *Id.* ¶ 29 & Ex. 8. The denial was based on State Department travel guidance for civilians, which referred to purported restrictions on the

[3] Service members' names have been anonymized and details of their circumstances generalized to preserve confidentiality. All of them are living with HIV, have no HIV-related symptoms, and have undetectable viral loads. Perkowski Decl. ¶ 24. Given the anonymity these service members requested, and the attendant procedural burdens associated with filing under seal, the facts related to the experiences to these service members are set forth in a declaration of counsel. Plaintiffs believe that these facts are not in dispute. Nevertheless, should Defendants or the Court object to this manner of presenting these facts, Plaintiffs are willing to obtain affidavits from each of these witnesses at the Court's request. *Id.* ¶ 23.

[4] MOD16 is the current version of the CENTCOM deployment policy that, as MOD13, was at issue in *Roe v. Austin*. Perkowski Decl. ¶ 4.

entry of HIV-positive people to Kuwait, the location to which the CENTCOM waiver authority mistakenly believed he was deploying. *Id.* ¶¶ 29-31 & Ex. 8. When SGT A.J. sought reconsideration based on the unit's actual destination, the ARNG waiver authority determined it was unnecessary to resubmit the waiver request after concluding that State Department travel restrictions (again, for civilians) for Saudi Arabia appeared similar to Kuwait's. *Id.* ¶ 32. On December 26, 2022, SGT A.J.'s unit mobilized without him. *Id.* After Plaintiffs' counsel intervened yet again, CENTCOM informally advised the ARNG that it likely *would* grant the waiver but only if the Army could transport SGT A.J. directly to Saudi Arabia without the usual stop in Kuwait. *Id.* ¶¶ 32-33. After additional delays associated with finding SGT A.J. commercial travel to Saudi Arabia (the Army does not fly directly there from the U.S.) and who would pay for it, SGT A.J. finally joined the rest of his unit in Saudi Arabia on February 19, 2023, almost two months after the others had left, thus depriving him of important aspects of pre-deployment training and preparation with his unit. *Id.* ¶¶ 35-37.

Lieutenant B.J.: Army First Lieutenant B.J. recently completed an Army commissioning program and in fall 2022 his initial post-program assignment was coming to an end. Perkowski Decl. ¶¶ 45-46. 1LT B.J.'s career manager advised him that he needed to be assigned to a deployable unit to advance his career. *Id.* But 1LT B.J. subsequently learned that he could not even get interviews for open positions in deployable units because his MRC classifies him as non-deployable. *Id.* To address this roadblock, 1LT B.J. spoke to Anthony B. Clark, Chief, Policy Procedures & Special Actions Branch of Army Human Resources Command ("HRC"). *Id.* ¶ 47. Mr. Clark confirmed that he was aware of new DoD policies governing the deployability of service members with HIV, but he informed 1LT B.J. via email that "even though the policy has changed, the policy is still the same." *Id.* Mr. Clark further told 1LT B.J.

that the Army "will not change" how it applies MRC codes for soldiers with HIV. *Id.* 1LT B.J. spoke to numerous other people at Army HRC—including MSG Teddy Lee Fain III, HRC Surgeon Sr. Medical NCO, and MAJ Stephanie Gasper, HRC Career Manager for his career field—to work through these issues, but to no avail. *Id.* ¶ 48.

To overcome the MRC code marking him as non-deployable, Mr. Clark advised 1LT B.J. that he needed to seek an exception to policy ("ETP") to be considered for an assignment to a deployable unit. *Id.* ¶ 49. But an ETP would take at least 90 days to process—not enough time before 1LT B.J.'s assignment cycle would close. *Id.* 1LT B.J.'s deadline to apply for positions ended on November 14 without resolution of this issue, and he took a less desirable assignment in a non-deployable unit. *Id.* ¶ 50. The inability to deploy without a medical waiver—made evident by the MRC code on his file—deprived 1LT B.J. of the professional opportunities afforded his peers who are HIV negative.

Petty Officer C.J.: In 2021, Petty Officer Second Class C.J. applied for a special-duty billet in the Defense Courier service, a prestigious and highly coveted assignment. *Id.* ¶¶ 38-39. He passed the medical screening, completed financial counseling requirements, and received "Top Secret" clearance. *Id.* When it came time for his detailer to cut orders, however, PO2 C.J. was flagged for HIV. *Id.* ¶ 41. PO2 C.J. had asked to be stationed in Sicily, but the detailer's commander, Lieutenant Commander Ryan Peterson, informed PO2 C.J. that the job might require him to deliver mail into Bahrain and Iran and claimed such travel was not permitted due to PO2 C.J.'s HIV status. *Id.* PO2 C.J. made LCDR Peterson aware of the HIV Memo, but that did not change anything. *Id.* ¶ 42. LCDR Peterson acknowledged being aware of the HIV Memo but responded: "As things are now yes, you are deployable. But currently per MILPERSMAN 1300-1300 that is limited to platforms with a fulltime medical officer assigned to it. … We'll see

if that changes when the new [Navy] instruction is released."[5] *Id.* ¶ 42 & Ex. 11.

When PO2 C.J. pointed out that he had previously traveled on military papers into Bahrain and even had liberty there (while he was living with HIV), LCDR Peterson said he "didn't want to hear that" and reiterated that he and the detailer no longer supported PO2 C.J.'s placement in the billet. *Id.* ¶ 43. PO2 C.J. tried again to convince LCDR Peterson by asking if the assignments requiring travel through Bahrain and Iran could be swapped to other couriers in the billet, but LCDR Peterson again refused, saying it was "just too much risk." *Id.* Defeated in his quest, PO2 accepted a less attractive post in a stateside billet. *Id.* ¶ 44.

Sergeant Nicholas Harrison: On April 6, 2023, a year after this Court ruled in his favor and required the Defendants to re-evaluate his application, SGT Harrison was finally offered a commission to join the Judge Advocate General Corps of the D.C. Army National Guard as a First Lieutenant. Perkowski Decl. ¶ 72. This is not the rank SGT Harrison was told his previous experience would merit (as of 2014). *Id.* Though he must commit to an additional eight-year obligation despite having become eligible for retirement in 2022, SGT Harrison finally has an offer in hand. *Id.* The process took a full year because Defendants made SGT Harrison start his application from scratch and required him to obtain medical and age waivers. *Id.* ¶¶ 69-71.

The revised commissioning (accessions) regulation states that HIV "is not, in itself, disqualifying" with respect to AHPSMUVL. Perkowski Decl. [Ex. A], Ex. 2B [DoDI 6130.03, Vol. 1 § 6.23(b)]. Only those with disqualifying conditions must secure a waiver under the regulation (*id.* § 1.2(e)), so the basis for requiring a medical waiver from SGT Harrison or any other AHPSMUVL is unclear. The regulation further states that AHPSMUVL will be "evaluated

[5] LCDR Peterson's reference to MILPERSMAN 1300-1300 is inexplicable: that document identifies Sigonella, Italy—the Sicilian base to which PO2 C.J. sought assignment—as one to which sailors living with HIV may currently deploy. Perkowski Decl. ¶ 21(c) (discussing MILPERSMAN 1300-1300, Ex. 1).

on a case-by-case basis," a caveat not found in the sections relating to any other medical condition. *Id.; see also infra*, Section IV.B.2. Though Defendants *appear* to have exempted AHPSMUVL from the mandates placed on those with a disqualifying condition, they have not in fact done so. SGT Harrison learned his age waiver had been approved in September 2022; he did not learn of his medical waiver for HIV until April 6, 2023. Perkowski Decl. [Ex. A] ¶ 71.

Movant Richard Roe: Technical Sergeant (E-6) Richard Roe continues to face restrictions on his deployability and barriers to deployment that he knows are likely to result in missed opportunities to build his military career.

In June 2022, two weeks after Defendant Austin issued the HIV Memo, TSgt Roe reached out to Medical Command at Brooke Army Medical Center to get his ALC changed or removed. Roe Decl. [Ex. B] ¶ 8. Because the HIV Memo states there will be "no restrictions on the deployability" of AHPSMUVL, TSgt Roe believed that the ALC designation would be removed from his file. *Id.* Medical Command informed TSgt Roe that the ALC would not be removed from his file or even reduced to a less restrictive level. *Id.*

TSgt Roe is legitimately concerned that the ALC on his file will limit his ability to deploy overseas or to be selected for other opportunities that require unrestricted deployability. TSgt Roe has witnessed how deployment tasking—the process for selecting unit members for inclusion in a deployment assignment, described above—is done. *Id.* ¶ 6; *see supra*, Section II.B.1. TSgt Roe is legitimately concerned that deployment tasking will be complete before he is even aware the unit has been ordered to deploy, much less has an opportunity to obtain the support of his chain of command, compile and submit a medical waiver application, and receive a decision regarding that application. *Id.* The imposition of an ALC—with its requirement to obtain a medical waiver—is an on-going barrier to deployment and injurious to TSgt Roe

because it is likely to deter or prevent his selection during deployment tasking, which will ultimately affect his military career.

Because Defendants have left in place all the mechanisms that prevented contingency deployments prior to the injunctions, Sergeant A.J. was not with his unit for the defining first two months of deployment, Lieutenant B.J.'s career prospects were diminished because he was not permitted to join a deployable unit, and Petty Officer C.J. was denied a coveted assignment for which he was fully qualified because his commanders thought he was ineligible to deploy to certain locations. Sergeant Harrison waited a full year before his medical waiver was granted, and Tech Sergeant Roe, like all AHPSMUVL, lives with the knowledge that the scarlet letter(s) on his file marking him as non-deployable likely will sideline him before he is even aware that a deployment opportunity has presented itself. The continuing harms to these AHPSMUVL are concrete and consequential; they can only be remedied by enforcement of the Court's injunctions and realization of presumptive deployability for AHPSMUVL as a consequence of those orders.

III. LEGAL STANDARD

A "party that obtains a judgment in its favor acquires a 'judicially cognizable' interest in ensuring compliance with that judgment." *Salazar v. Buono*, 559 U.S. 700, 712 (2010) (plurality). "Having obtained a final judgment granting relief on his claims," the plaintiff possesses "standing to seek its vindication." *Id.*; *see also Cape Hatteras Access Pres. All. v. U.S. Dep't of Interior*, 731 F. Supp. 2d 15, 20 (D.D.C. 2010) (recognizing where "plaintiffs obtained a judgment in their favor . . . and are seeking judicial review challenging whether the [Defendant] complied with the [order] . . . plaintiffs have demonstrated constitutional standing"). Otherwise, defendants could refuse to comply with the full scope of an injunction, such as by permitting the same-sex couples named as plaintiffs to marry while refusing to permit other same-sex couples

to do the same. *Cf. Bostic v. Rainey*, 970 F. Supp. 2d 456, 461 (E.D. Va. 2014) (enjoining exclusion as to all otherwise-qualified same-sex couples).

"To ensure compliance with its orders, a district court has the inherent authority to hold parties in civil contempt." *Rainbow Sch., Inc. v. Rainbow Early Educ. Holding LLC*, 887 F.3d 610, 617 (4th Cir. 2018) (citing *Shillitani v. United States*, 384 U.S. 364, 370 (1966)). To prove civil contempt, the movant must demonstrate four elements by clear and convincing evidence:

> (1) the existence of a valid decree of which the alleged contemnor had actual or constructive knowledge; (2) that the decree was in the movant's 'favor'; (3) that the alleged contemnor by its conduct violated the terms of the decree, and had knowledge (at least constructive knowledge) of such violations; and (4) that the movant suffered harm as a result.

Rainbow Sch., 887 F.3d at 617 (citations omitted). The order allegedly violated must be one that set forth "'in specific detail an unequivocal command' which a party has violated." *In re Gen. Motors Corp.*, 61 F.3d 256, 258 (4th Cir. 1995) (citations omitted). At the same time, parties are expected to comply with both the letter and the spirit of a court's orders. *See McComb v. Jacksonville Paper Co.*, 336 U.S. 187, 191-93 (1949); *John B. Stetson Co. v. Stephen L. Stetson Co.*, 128 F.2d 981, 983 (2d Cir. 1942) ("In deciding whether an injunction has been violated it is proper to observe the objects for which the relief was granted and to find a breach of the decree in a violation of the spirit of the injunction, even though its strict letter may not have been disregarded."); *North Carolina State Conf. of the NAACP v. McCrory*, 214 F. Supp. 3d 466, 473 (M.D.N.C. 2016); *Folk v. Standard Bus. Forms, Inc.*, 270 F. Supp. 147, 156 (W.D.N.C. 1967) ("the authorities are replete to the effect that" it is sufficient that there is "a violation of the spirit of the injunction, even though its strict letter may not have been disregarded.").

While "[s]ubstantial compliance with a decree is a defense to civil contempt, [s]ubstantial compliance is found where *all* reasonable steps have been taken to ensure compliance:

inadvertent omissions are excused only if such steps were taken." *De Simone v. VSL Pharms., Inc.*, 36 F.4th 518, 530 (4th Cir. 2022) (emphasis added) (citation omitted). Even when there is "[n]o doubt" that contemnor took steps to ensure compliance, it needs to have taken "all reasonable steps" to ensure compliance to avoid contempt. *Id.* Intent is irrelevant to a finding of civil contempt. *See McComb*, 336 U.S. at 191.

IV. ARGUMENT

Defendants' failure to place AHPSMUVL on par with service members with other well-managed chronic conditions by making them presumptively deployable and eliminating the requirement that they obtain a medical waiver to deploy or commission has resulted in non-compliance with this Court's injunctions. Defendants indisputably had actual knowledge of the Court's injunctions (as amended), so only the third and fourth elements of the legal standard are at issue here. As shown by clear and convincing evidence below, Defendants violated the terms of the injunctions and are aware of the effect their failure to abide is having on service members living with HIV. As described throughout this brief, harms to service members living with HIV include unnecessary scrutiny from commanders and decisionmakers, reduced appeal as a candidate for various assignments, disclosure of HIV status to non-medical personnel, potential privacy violations, and the greater likelihood of arbitrary, inconsistent, and unsubstantiated decisions on deployment and commissioning. Movant Richard Roe continues to experience harm from being labeled as presumptively non-deployable. MMAA has continued to expend resources to address these harms and the barriers service members living with HIV are facing as a result of Defendants' failure to comply with the Court's orders.

Read in light of the comprehensive record and well-supported opinion on summary judgment, *see Harrison*, 597 F. Supp. 3d at 915 (relying heavily on "the Fourth Circuit's

forceful, unanimous opinion"), the only reasonable construction of the Court's injunctions is that they prohibit Defendants from refusing to deploy a service member based on their HIV-positive status if the service member has an undetectable viral load and is asymptomatic. *See id.* at 916 ("Defendants' policies prohibiting the commissioning and retention of HIV-positive service members who are asymptomatic and have undetectable viral loads are irrational as well as arbitrary and capricious."). That is, Defendants cannot apply an HIV-based bar to service members with HIV who meet these two objective criteria. The categorical bar applies to HIV-positive service members who do not meet those two criteria and for those seeking to join the military, but it can no longer be applied to AHPSMUVL. *See id.* at 890 n.5.

In November, Plaintiffs sent a letter to Defendants' counsel seeking an explanation and relief for the service members discussed above. Perkowski Decl. [Ex. A] ¶ 75 & Ex. 16. In a subsequent conversation with counsel, Defendants maintained that the decisions made with respect to those service members complied with the injunctions despite reliance on their HIV status to deny deployment or restrict their mobility. Perkowski Decl. [Ex. A] ¶¶ 76-78. Defendants appear to believe that compliance requires only that *some* AHPSMUVL be allowed to deploy and commission because that renders the bars no longer "categorical." This position would be impossible to square with the both the plain language and the spirit of the injunctions, the record on summary judgment, and the Court's opinion and rulings in Plaintiffs' favor.

A. The Orders Prohibit Defendants from Using HIV Status to Deny Deployment or a Commission to an Asymptomatic HIV-Positive Service Member with an Undetectable Viral Load.

Rather than framing the orders to mandate that Defendants take specific actions—for instance, to deploy AHPSMUVL—the Court appropriately phrased them as a prohibition: Defendants cannot apply their deployment and commissioning bars to service members with HIV who are asymptomatic and have an undetectable viral load. The Court was unequivocal: the

bars cannot be applied to plaintiffs Richard Roe, Victor Voe, Nicholas Harrison, or "any other asymptomatic HIV-positive service member with an undetectable viral load." *See supra*, Section II.A (quoting orders). To Movants, the scope and impact of the orders is clear: Defendants cannot deny deployment or a commission to *any* AHPSMUVL merely because that person is categorized as HIV-positive. Plaintiffs' understanding of the plain meaning and consequence of the orders is further supported by the comprehensive nature of this litigation and the Court's opinion on summary judgment, which in turn was based on a voluminous record. *See Harrison*, 597 F. Supp.3d at 891 (describing the extensive record on summary judgment).

From the beginning, all parties understood that Plaintiffs were challenging the constitutionality of the bars to deployment and commissioning for people living with HIV, both as applied specifically to Plaintiffs and facially to the broader category of all service members with HIV. *Harrison*, 597 F. Supp. 3d at 905 (noting that Plaintiffs' equal protection claims were clearly stated from the outset). As part of the equal protection challenge (in both lawsuits), Defendants had the opportunity to offer—and did offer—every conceivable justification for the bars. Mem. in Supp. of Def.'s Cross-Mot. for Summ. J. and Opp. to Pl.'s Mot. for Summ. J, ECF 264, *Harrison v. Austin*, No. 1:18-cv-641 (LMB/IDD) (E.D. Va. June 3, 2020) ("Defs.' S.J. Mem."). In turn, Plaintiffs had the responsibility to demonstrate—and did demonstrate—that each of Defendants' purported justifications failed to meet the requisite degree of judicial scrutiny to save the bars from invalidation. Comb. Reply in Supp. of Pl.'s Mot. for Summ. J. and Opp. to Def.'s Mot. for Summ. J., ECF 285, *Harrison v. Austin*, No. 18-cv-641 (LMB/IDD) (E.D. Va. July 2, 2020). In the end, the Court determined that none of Defendants' purported justifications satisfied even rational basis review. *Harrison*, 597 F. Supp. 3d at 911, 915. After this lengthy litigation—with extensive discovery—and the ample opportunity Defendants had to

offer a rational basis for the refusal to deploy or commission service members with HIV, an interpretation of the Court's orders that leaves Defendants with the continuing ability and discretion to refuse to deploy or commission AHPSMUVL based on their HIV-positive status is antithetical to the integrity and utility of the judicial process.

This flaw in the Defendants' interpretation of the Court's orders is brought into greater relief by the Court's summary judgment opinion. In it, the Court addressed each of the justifications proffered by the Defendants—including the purported "host nation requirements" (or "foreign country restrictions") that appear to form the basis for denying or delaying deployments or reassignment to at least two service members with HIV in recent months—and rejected them as failing to provide a rational basis for the deployment bar. *Id.* at 908. In particular, the Court noted that the Fourth Circuit had rejected the foreign country restrictions argument as unsupported by the record and stated that the "summary judgment record is no different on these points." *Id.* at 908 n.22. And that record was unsupported on this issue despite extensive discovery conducted on the subject. Mem. in Supp. of Pl.'s Mot. for Summ. J. at 37, *Harrison v. Austin*, No. 1:18-cv-641 (LMB/IDD) (E.D. Va. May 4, 2020) ("Pl.'s S.J. Memo"), ECF 255 (describing testimony from *two* depositions of Dr. Donald Shell, Defendants' 30(b)(6) witness on foreign country restrictions); Def.'s S.J. Memo, ECF 264, at 8. Furthermore, the Court's orders specifically identify the Central Command area of operations ("CENTCOM") as an area to which AHPSMUVL cannot be denied deployment—and the countries to which some AHPSMUVL are being denied deployment based on supposed foreign country restrictions are within CENTCOM. *See supra*, Section II.A (quoting orders); *see also supra*, Section II.B.2 at 9, 11. Given the ample opportunities Defendants had to present arguments and proffer evidence in support—and the Court's disposition of all that were presented—Defendants are not now at

liberty to rely on those purported justifications or to formulate new ones to deny AHPSMUVL the ability to deploy or to commission based on their HIV status.

Though not explicitly stated in the HIV Memo, AHPSMUVL are still required to secure a medical waiver to deploy or to be granted a commission, as confirmed by the experiences of recent applicants. *See supra*, Section II.B.2. A medical waiver is *not required* for service members with any other health condition who satisfy the criteria for that condition that keep them presumptively deployable under the regulation regarding deployment-limiting conditions. Perkowski Decl. [Ex. A], Ex. 6 [DoDI 6490.07, Encl. 2, ¶ 2(a)]. As the Court noted:

> In stark contrast to the military's treatment of HIV-positive service members, service members with various chronic but manageable conditions can qualify for accession and deployment *without a medical waiver* based on individualized considerations of the severity of their diagnoses which are expressly set out in the relevant Department of Defense Instructions.

Harrison, 597 F. Supp. 3d at 905 (emphasis added). Even after Defendants' implementation of the injunctions, the "stark contrast" continues. AHPSMUVL are still considered presumptively non-deployable and must secure a medical waiver.

Requiring a waiver for HIV when a waiver is not required for other chronic manageable health conditions constitutes an on-going equal protection violation. *Harrison*, 597 F. Supp. 3d at 915 ("[T]he plaintiffs in *Roe* and *Harrison* have established that the military's categorical deployment bar irrationally treats HIV-positive service members who are asymptomatic with undetectable viral loads differently than service members with other chronic but manageable conditions."). The uncertainty of outcome, arduous application process, discretion to deny without explanation, potential privacy and confidentiality violations, and other negative connotations associated with waivers for HIV make that equal protection violation an egregious one. The waiver application process is not merely a *pro forma* step (*see supra*, Section II.B.1 at 5-7), and Defendants go out of their way to make clear that service members with HIV will be

scrutinized more rigorously than others seeking a medical waiver. Perkowski Decl. [Ex. A], Ex. 1 [HIV Memo] *passim* (repeatedly stating that AHPSMUVL will be evaluated on a "case-by-case basis"); *id.* Ex. 2B [DoDI 6130.03, Vol. 1, § 6.23(b)] (including "case-by-case basis" language that does not appear with respect to any other condition); *id.* Ex. 6 [DoDI 6490.07, Encl. 3, ¶ (e)(2)] (requiring Combatant Command surgeon approval prior to deployment clearance, which is not required for any other condition).

Even on paper, applying for a medical waiver is an onerous process, requiring AHPSMUVL to address each of the factors in DoDI 6490.07 to overcome the presumption of non-deployability. *See supra*, Section II.B.1. In essence, it requires each AHPSMUVL to relitigate these cases without the assistance of a legal team and HIV medical experts who are not biased against people living with HIV. If Plaintiffs did not establish through more than four years of litigation—involving hundreds of thousands of dollars in costs and fees—that AHPSMUVL should be presumptively deployable, then their victory was pyrrhic.

To be clear, Movants are not suggesting that AHPSMUVLs be exempted from the pre-deployment medical evaluation to which all service members are subject. Rather, Movants submit that, like other service members with chronic health conditions, the pre-deployment medical evaluation should be conducted based on a pre-deployment health assessment and the service member's medical records. Perkowski Decl. [Ex. A], Ex. 6 [DoDI 6490.07, Encl. 2, ¶ 1] (making the pre-deployment health assessment and medical record review a mandatory part of the pre-deployment medical assessment for all DoD personnel before serving on a contingency deployment). And medical records should always be up to date for this sub-population because follow-up care—including viral load testing and a physician visit—is conducted for service members with HIV at a maximum interval of every six months. *See id.* (requiring a current

periodic health assessment as part of the pre-deployment medical assessment for contingency deployments). These pre-deployment reviews and assessments, which are required for all service members engaging in a contingency deployment, provide leadership with all the information needed to assess whether the service member with HIV is asymptomatic and has an undetectable viral load. In short, the additional burden of a medical waiver is not necessary to ensure that a member living with HIV is medically qualified to serve in a contingency deployment.

By definition, those who do not require a waiver are preferred over those who do; if qualified service members who do not need a waiver are plentiful, the motivation to dip into the pool of those requiring a waiver goes down. Roe Decl. [Ex. B] ¶ 6. In addition to making them less attractive candidates, continuing to require AHPSMUVL to obtain a medical waiver subjects them to unnecessary scrutiny, disclosure of their HIV status to non-medical personnel, potential privacy violations, and arbitrary or unsubstantiated deployment and commissioning decisions. *See supra*, Section II.B.2.

The presumption of deployability to which AHPSMUVL are now entitled should include a change to or removal of any designation indicating that they are non-deployable or presumptively non-deployable for medical reasons. For Army members, this involves changing their MRC, and for Air Force members, this would involve a change to their ALC. Perkowski Decl. ¶¶ 10-19. Typically, members of the Air Force living with HIV are given an ALC of C2, which defines them as eligible only for assignments within the continental United States ("CONUS") with some exceptions "if appropriate care is available" at an overseas base or non-fixed facility. Perkowski Decl. [Ex. A] ¶¶ 10-14. In fact, none of the "C" codes—C1, C2, or C3—accurately describes the deployability of AHPSMUVL (*id.* ¶ 13); this misclassification acts as a barrier not only to deployment but also to certain domestic and overseas assignments, many

educational and training opportunities, and overall career advancement. The ALC for AHPSVUVL should be eliminated altogether because the lowest (C1) is generally applied to conditions that are stable and not likely to worsen suddenly (like well-managed HIV) but that *also* require or may require easily accessible medical treatment facilities; AHPSMUVL do not require easy or regular access to a medical treatment facility. Under the Army's similar classification system, those who are fully medically ready are designated MRC 1, which would be the appropriate classification for AHPSMUVL. Until MRCs, ALCs, and similar designations are modified to reflect their presumptive deployability, AHPSMUVL will continue to face systemic barriers in violation of equal protection.

B. Defendants Are Not in Compliance with the Permanent Injunctions.

An interpretation of the Court's orders that merely prohibits an absolute bar of AHPSMUVL does not comport with the judgment in Plaintiffs' favor or the opinion in support of summary judgment. And, if taken literally, such an interpretation would render the orders a nullity. Even if Defendants were able to establish that the HIV Memo was intended to lift the discriminatory restrictions on deployment and commissioning for AHPSMUVL, the mixed messages of that Memo and failed translation of the key elements of the HIV Memo into the regulations upon which commanders and their staffs rely to guide their daily decision-making on personnel actions have resulted in non-compliance with the Court's injunctions.

1. Defendants' interpretation of the orders is incompatible with the opinion and rulings on summary judgment.

Defendants are expected to argue that the outcomes that 1LT B.J., SGT A.J., and PO2 C.J. experienced are consistent or compliant with the Court's injunctions because they prevent only a "categorical" exclusion of AHPSMUVL from deployment. Perkowski Decl. [Ex. A] ¶¶ 73-81. In defending the decisions to deny deployment or special assignment to SGT A.J. and

PO2 C.J., counsel stated that the injunctions prevented Defendants from *categorically* barring the deployment of AHPSMUVL and noted that at least one waiver to deploy had been granted. Perkowski Decl. [Ex. A] ¶¶ 78-81 & Exs. 18, 19. This argument suggests that the orders' use of the term "categorically" permit Defendants to continue to deny deployments and commissions, based on their HIV-positive-status, to at least some AHPSMUVL some of the time. This is not how Movants understand the Court to be using "categorically" in its orders.

Though one of the definitions of the word categorically is indeed "absolute" or "unqualified," the other definition is "of, relating to, or constituting a category." *See* https://www.merriam-webster.com/dictionary/categorical. Both this Court and the Fourth Circuit at times used the term "categorical bar" to refer to a policy of denying contingency deployment or a commission to individuals who fall into a category labeled "persons with an HIV diagnosis." *See Roe v. Dept. of Defense*, 947 F.3d 207, 234 (4th Cir. 2020) (describing Defendants "relying upon assumptions and categorical determinations" (*i.e.,* decisions about individuals based on membership in a particular group or category)); *id.* at 232 ("[T]the Government used an unexplained categorical policy, which effectively operated as a ban"); *id.* (stating "the categorical polices relied upon by the Government call for categorical relief" in affirming injunctive relief for other Airmen with HIV); *Harrison*, 597 F. Supp. 3d at 906 (describing the particularized assessments given to others that individuals with HIV are denied categorically); *see also* Pls.' S.J. Memo *passim* (repeatedly using the word in this sense). *And* the Court used Defendants' preferred definition, but caveated its use from the outset of the opinion to acknowledge that the HIV bar was *not* absolute. *Harrison*, 597 F. Supp. 3d at 889 ("Both policies are based on a *virtually* categorical determination by the military … .") (emphasis added); *id.* at 890 (referring to "an *essentially* categorical ban on the worldwide deployment of

any service member who is HIV-positive") (emphasis added). Both definitions of "categorical" are viable, but if applied in the context of the injunctions, the former definition would mean the Court prohibited *only* an absolute bar that the Court recognized never even existed. The injunctions are meaningful only if they prohibit Defendants from maintaining a bar applying to all service members living with HIV—one type of "categorical" bar—even if that bar is not absolute and results in the deployment and commissioning of some service members with HIV.

If Defendants' interpretation is correct, it is unclear what factors Defendants think the Court is permitting them to still consider by prohibiting only an "absolute" bar. If Defendants think the Court intended to give them leeway to deny deployment or commissioning based on some other aspect of a service member's HIV-related health or HIV status, that is not contemplated anywhere in the Court's opinion or orders. Such an approach would be antithetical to the comprehensive inquiry and thorough analysis required—and engaged in by the Court—under equal protection. *Id*. at 900-01 (assessing the validity of "the deployment bar—whether categorical or not"). The Court considered all the purported justifications that Defendants offered for denying contingency deployments and commissions to service members living with HIV—and rejected all of them as irrational with respect to AHPSMUVL. *See id.* at 901-14. Alternatively, if Defendants believe the word "categorically" was included to give them latitude to base a denial on some other aspect of a service member's health or on other attributes unrelated to HIV, Defendants are mistaken and need not concern themselves with the definition of that word under such circumstances, because the injunctions apply only to denials "due to…HIV-positive status." *See supra*, Section II.A. (quoting orders).

Perhaps most significantly, defining categorically as "absolutely" or "completely" renders the Court's orders a nullity and returns the parties to the *status quo ante*. Taken literally

and to its extreme but logical conclusion, that interpretation would place Defendants in compliance if they allowed a single AHPSMUVL to deploy; that certainly would not be acceptable. *See Hobson v. Hansen*, 269 F. Supp. 401, 502 (D.D.C. 1967) ("the Constitution is not appeased by tokenism."). Furthermore, compliance would not depend on whether even a pretextual reason was offered in denying a waiver—that is, as long as the waiver process is available for service members with HIV, the actual outcome of those waiver requests would be irrelevant. This approach is indistinguishable from the state of affairs that the Court already considered and rejected: the medical waiver process was available for service members with HIV who wished to deploy—and in extreme circumstances, some waivers or exceptions even were granted to members of the Special Forces (*see* Pl.'s S.J. Mem., ECF 255, at 19)—but the general practice was to deny all service members with HIV. *See Harrison*, 597 F. Supp. 3d at 900. It is doubtful the Court intended to give the Defendants free reign to continue to rely on their irrational prejudices regarding HIV to set policy and to leave service members with HIV at the whim of uninformed decisionmakers—but that is the outcome if "categorically" means absolutely in the injunctions.

In light of the Court's rulings and orders, Movants do not think Defendants are or should be permitted to exercise *now* the same degree of latitude they exercised *before* these lawsuits in making deployment and commissioning decisions for service members living with HIV.

2. Changes to Defendants' HIV-related personnel policies have not resulted in compliance with the Court's orders.

Furthermore, any argument that Defendants have cabined the discretion of decisionmakers in accordance with the Court's injunctions through the HIV Memo does not hold water. The HIV Memo sends mixed signals, does not eliminate the waiver requirement, and attempts to retain a level of discretion to deny deployments and commissions that is incompatible

with the orders of the Court. Furthermore, Defendants failed to include in any of the regulatory changes the one directive from the HIV Memo that could guide decisionmakers in exercising any discretion they may have to deny deployment to AHPSMUVL based on their HIV status.

The HIV Memo itself sends mixed messages about service members living with HIV. In describing the changes to policy, the HIV Memo uses language that appears to signal compliance with the Court's injunctions, stating that asymptomatic HIV-positive service members with an undetectable viral load will "have no restrictions applied to their deployability or to their ability to commission … ." Perkowski Decl. [Ex. A], Ex. 1 [HIV Memo], at 1. However, it tempers that seemingly definitive statement with the caveat that restrictions will not be " … *solely* on the basis of their HIV status." *Id.* Indeed, though the word does not appear in the Court's orders, the HIV Memo uses some version of "solely" or "in itself" regarding HIV every time it restates the new standard by which service members with HIV are to be evaluated. *Id. passim.*

This language choice should be familiar. As the Court will recall, the Air Force used this same wiggle word—"solely"—to argue that it was not discharging Plaintiffs Roe, Voe, and several others based "solely" on their HIV-positive status (in contravention of Air Force regulations) because those discharges were based on both HIV status and the "deployment tempo" of the positions these service members held in the Air Force. *Harrison,* 597 F. Supp. 3d at 914-15. In finding the discharges in violation of the APA, the Court called this a "hyper-technical and circular argument that misses the mark[,]" because both purported bases for discharge hinged on the individuals' inability to deploy because of their HIV-positive status. *Id.* at 915. The same assessment applies here: Defendants seem to have inserted the word "solely" into the regulations concerning the deployment, commissioning, and discharge of service members with HIV to permit decisionmakers to do what the Court said the Air Force could not:

use thinly disguised non-HIV-related reasons as a pretext to deny service members with HIV the ability to deploy, commission, or remain in the military. The only reasons to include these wiggle-words are to narrow the injunctions' applicability, to signal to military decisionmakers that HIV-positive status may still be used in combination with another factor to restrict AHPSMUVL, and to provide a basis to argue that Defendants are complying with the injunctions while continuing to deny deployments and commissions to service members living with HIV. The Court should not allow Defendants to reinterpret or revise the injunctions in this way.

In addition to narrowing the injunctions, Defendants failed to translate the provisions of the HIV Memo into regulations in a manner that places HIV on par with other chronic, manageable conditions.[6] For commissioning, instead of placing the criteria for service members without HIV-based restrictions in the section of the regulation pertaining to HIV—as is the practice for every other health condition listed—the DoD distinguishes the handling of "covered personnel" there. Perkowski Decl. [Ex. A], Ex. 2B [DoDI 6130.03, Vol. 1 § 6.23(b)]. In the very same paragraph, "covered personnel" is partly defined as those seeking to commission while a service member (*i.e.*, not recruits), including cadets and midshipmen, etc. *Id.* The *only* thing missing from the paragraph pertaining to HIV are the criteria by which HIV is rendered inconsequential to the commissioning decision. Instead, those health metrics (*i.e.,* asymptomatic and undetectable) are found in the definition of "covered personnel" in the glossary, making HIV the only condition handled in this fashion. *Id.* The provision on HIV further states that "covered

[6] In apparent agreement with the Court that Plaintiffs' claims implicated policies throughout the Services (*Harrison*, 597 F. Supp.3d at 893), the HIV Memo closes by requiring the Secretaries of the Military Departments and the Combatant Commanders to revise their respective regulations, policies, and other guidance to be consistent with the Memo "no later than 60 days from the date of this memorandum." Perkowski Decl. [Ex. A] Ex. 1. As of this filing, 274 days since the Memo published, Plaintiffs' counsel is aware of no such service-level or Combatant Command-level changes to regulations, policies, or other guidance. Perkowski Decl. ¶ 5.

personnel shall be evaluated on a case-by-case basis" (*id.*), which is being interpreted and applied as requiring a waiver. *See supra*, Section II.B.2 at 11. No other medical condition listing in DoDI 6130.03 includes such language. Handling HIV differently—and not including the criteria defining well-managed HIV in the section pertaining to HIV—sends a message and makes it more difficult for HIV-positive service members to secure a commission.

With respect to the deployment of service members living with HIV, Defendants did not amend the regulations *at all*. Perkowski Decl. [Ex. A] ¶ 3. Thus, Defendants concluded that the language of the DoD deployment regulation—which still lists HIV as a presumptively deployment-limiting and has been misinterpreted and misapplied to maintain the *de facto* bar to the deployment of service members with HIV since 1996, when those successfully treated no longer had "progressive clinical illness or immunological deficiency"—should be left as it is. While the HIV Memo states that deployment decisions for covered personnel must be "justified by the service member's inability to perform the duties to which he or she would be assigned," that language is not found anywhere in the revised regulation. Even the purported limitation in the Memo—that deployment decisions "must be justified"—reads as if non-deployment is the default that needs to be overcome. Perkowski Decl. [Ex. A], Ex. 1. Defendants' failure to officially memorialize the Court's deployment-related rulings in a regulation is likely why service members with asymptomatic HIV and an undetectable viral load still are experiencing barriers to deployment and reassignment—barriers not based on, in the words of the HIV Memo, "the service member's inability to perform the duties to which he or she would be assigned." *Id.*

Decisionmakers look to regulations, and without changes to regulations, those decisionmakers will continue to operate in the same old ways. This is borne out by the experiences of service members with HIV recounted above, each of whom was told that current

(unchanged) regulations would be followed until further guidance is issued. *See supra*, Section II.B.2. Defendants' decision to implement the injunctions by *not making any changes* to the deployment regulation sends a clear message: the old way is still the correct way.

That Defendants viewed the post-injunction operational reality to be only minimally changed is conveyed in the communication plan that accompanied the issuance of the HIV Memo and talking points provided for the briefing held that day. Perkowski Decl. [Ex. A], Ex. 5 [Comm Plan]. That document twice states that AHPSMUVL will not be "categorically barred," suggesting the belief that military leaders retain the discretion to bar such individuals, because they will be evaluated on a "case-by-case basis" (which the Comm Plan repeats no fewer than six times) and because restrictions on their service are prohibited only if their HIV-positive status is the *sole* basis for those restrictions (repeated three times). *Id.* Shockingly, after explaining the supposedly new policies and explicitly reassuring its audience that the policy does not require the deployment of all HIV-positive service members, the Comm Plan then states (twice) that the approach in the Memo "is consistent with the way most DoD components already handle HIV-positive service members." *Id.* In other words: nothing has changed, and you can keep doing exactly what you were doing before the HIV Memo issued. Given the business-as-usual messaging, it is no wonder that service members with HIV continue to face the same or similar barriers to deployment and commissioning they faced before the injunctions.[7] As Lieutenant B.J. was told: "even though the policy has changed, the policy is still the same."

[7] The HIV Memo also created a working group tasked with developing proposed standards for conducting the "case-by-case" review of AHPSMUVL, specifying that such standards will include the "period during which" they must exhibit an undetectable viral load. Perkowski Decl. [Ex. A] Ex. 1. The Court's orders, however, did not contemplate a period during which the service member with HIV must have an undetectable viral load (or be symptom free), likely because the record on summary judgment contained evidence demonstrating that 99.8% of all service members with HIV achieve an undetectable viral load and no evidence that any significant number of them subsequently have a non-suppressed viral load. Pl.'s S.J. Mem., ECF 255, at 22, 25.

Directives from leadership that are explicit, unequivocal, and properly placed are particularly important in these circumstances, where an erroneous policy and contrary message—further supported by misconceptions and fears deeply ingrained in the public consciousness—have been conveyed, maintained, and reinforced over many years. If not in fact intended to "hide the ball" and to signal to lower-level decisionmakers that they may proceed with business as usual, the regulatory changes made (sometimes not made), the mixed messages conveyed by those convoluted changes, and the accompanying communication plan undoubtedly contributed to Defendants' failure to comply with the injunctions entered by this Court.

V. CONCLUSION

Movants respectfully request the Court to issue an order to show cause why Defendants should not be held in contempt, to find that Defendants are not in compliance with the permanent injunctions entered in this case, and to clarify Defendants' obligations under those orders. Movants further submit that a process whereby the Court reviews and approves Defendants' proposed actions and regulatory changes to bring them into compliance—including an opportunity for Movants to comment upon those proposed changes—would be an appropriate way to proceed given Defendants' failure to abide by the Court's orders over the past twelve months. Furthermore, Movants ask the Court to conduct additional oversight to ensure full compliance with its permanent injunctions over the next two years. Alternatively, if the Court determines that the current injunctions are insufficient to address the on-going violations of equal protection established on summary judgment, Movants ask the Court to modify the injunctions to fully remedy those violations.

Dated: May 3, 2023

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that, on May 3, 2023, I caused this document to be filed electronically through the Court's CM/ECF system, which automatically sent a notice of electronic filing to all counsel of record.

Dated: May 3, 2023

Respectfully submitted,

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Exhibit A

Perkowski Declaration

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

NICHOLAS HARRISON, et al., Plaintiffs, v. LLOYD J. AUSTIN, Secretary of Defense, et al., Defendants.	Civil Action No. 1:18-cv-641 (LMB/IDD)
RICHARD ROE, et al., Plaintiffs, V. LLOYD J. AUSTIN, Secretary of Defense, et al., Defendants.	Civil Action No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF PETER PERKOWSKI

1. My name is Peter Perkowski, counsel for Plaintiffs in these actions. I am over 18 years of age, am competent to testify about the information contained in this declaration if needed, and offer this declaration based on my own actual, personal knowledge, some of which was obtained in the course of my work on these cases.

Defendants' Response to the Court's Rulings in this Matter

2. The Court granted summary judgment in Plaintiffs' favor in April 2022 and simultaneously issued two sets of orders, which enjoined Defendants from taking certain actions with respect to service members with HIV. (The April 2022 Orders were slightly revised in May 2022, but to avoid confusion, in this declaration I will refer to them as the Court's "April 2022 Orders.") Two months later, on June 6, 2022, Defendants took the following actions:

a. Defendant Secretary of Defense Lloyd Austin III issued a Memorandum Re: Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces (the "HIV Memo"). The HIV Memo was directed to Senior Pentagon Leadership, Commanders of the Combatant Commands, and Defense Agency and DOD Field Activity Directors. The HIV Memo is attached to this declaration as Exhibit 1.

b. Among other things, the HIV Memo announced the revision of three Department of Defense Instructions ("DoDI"):

(i) DoDI 6130.03, Volume 1, *Medical Standards for Military Service: Appointment Enlistment, or Induction* (June 6, 2022), which is attached to this declaration as Exhibit 2A. Defendants revised and reissued DoDI 6130.03, Volume 1 again in November 2022; that version is attached as Exhibit 2B.

(ii) DoDI 6485.01, *Human Immunodeficiency Virus (HIV) in Military Service Members* (June 6, 2022), which is attached to this declaration as Exhibit 3; and

(iii) DoDI 6130.03, Volume 2, *Medical Standards for Military Service: Retention* (June 6, 2022), which is attached to this declaration as Exhibit 4.

c. Defendants also issued a communication plan regarding the new HIV policies. U.S Department of Defense, *Communication Plan: Policy Regarding HIV-Positive Personnel Within the Armed Forces* (June 7, 2022), attached to this declaration as Exhibit 5.

3. Defendants made no changes to the deployment regulation, DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees* (Feb. 5, 2010). As it did before the April 2022 Orders, that regulation still requires all service members with HIV, including Airmen and Soldiers, to obtain a medical waiver to qualify for a

contingency deployment. *See* DoDI 6490.07, Encl. 3, ¶ e(2). DoDI 6490.07 is attached to this declaration as Exhibit 6.

4. Though the HIV Memo directed the Secretaries of the Military Departments and the Commanders of the Combatant Commands to revise regulations under their purview within 60 days to make them consistent with the HIV Memo, to my knowledge, no service- or combatant-command-level regulations pertaining to HIV have changed since the April 2022 Orders. Thus, Army Regulation ("AR") 600-110, *Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus* (22 April 2014), remains unchanged; Air Force Instruction ("AFI") 44-178, *Human Immunodeficiency Virus* (4 March 2014), remains unchanged; SECNAV Instruction ("SECVANINST") 5300.30F, *Management of Human Immunodeficiency Virus, Hepatitis B Virus, and Hepatitis C Virus in the Navy and Marine Corps* (27 Dec. 2018), remains unchanged; and the HIV-specific sections of MOD Sixteen to USCENTCOM Individual Protection and Individual-Unit Deployment Policy ("MOD16")—an earlier version of which, MOD13, the Court analyzed in its summary judgment opinion, remain unchanged.

5. The HIV Memo also instructed the Under Secretary of Defense for Personnel and Readiness ("USD(P&R)") to convene a working group ("HIV Working Group") to "develop proposed standards for conducting the case-by-case determinations" of service members with HIV. (*See* Ex. 1.) In the Memo, the Working Group was directed to "report those proposed standards to [the Secretary of Defense] within six months." (*Id.*) If the Working Group reported those proposed standards as instructed, the report has not been made public or available to Plaintiffs' counsel. Moreover, to my knowledge, neither the USD(P&R) nor Defendant Austin has yet taken any action on any recommendations of the HIV Working Group.

6. The HIV Memo did not charge the HIV Working Group with examining and proposing accessions standards for people living with HIV who are not yet serving and therefore not addressed in the June 2022 revised regulations. Nevertheless, as the time drew near for Defendants' responsive pleading in the new case challenging the regulations preventing all people with HIV from joining the military (*Wilkins v. Austin*, No. 1:22-cv-01272 (LMB/IDD)), the USD(P&R) issued a memo to the Chair of the HIV Working Group stating, among other things, that the HIV Working Group should be "considering whether DoD should make any changes to accessions policy for HIV-positive individuals not covered by the Secretary's June 6, 2022 memorandum." A copy of this February 10, 2023 memo is attached to this declaration as Exhibit 7. In the memo, the USD(P&R) instructed: "I hereby direct the working group to provide a recommendation to me concerning whether to amend DoD's accessions policy, as it pertains to HIV-positive individuals seeking to join the military, no later than April 1, 2023."

Experiences of HIV-Positive Service Members Since the April 2022 Orders

7. Since the April 2022 Orders, I have received numerous calls, texts, and emails from service members with HIV who are experiencing barriers or difficulties in applying for commissioning programs, being deployed, obtaining new assignments, or attempting to obtain a permanent change of station ("PCS").

8. I have communicated with these service members by telephone and other means, and I collected relevant documents, including emails, from them. Some of the facts set forth below are based on those documents and conversations.

Medical Limitation Codes and Restrictions on Service Members with HIV

9. In talking with service members with HIV, I have learned that the barriers and restrictions these service members are experiencing are embedded in the systems that the service

branches use to track and limit people with chronic conditions that make them presumptively non-deployable. Directly below, I describe those systems and policies, which are applicable to all service members with HIV and are identical to the systems and policies that existed before the April 2022 Orders.

Air Force

10. In the Air Force, Airmen with duty-limiting conditions may be returned to duty with an Assignment Limitation Code ("ALC"). Broadly speaking, "[a]ssignment limitations … are used to alert personnel managers of long term constraints on assignment or utilization of Airmen. They broadly restrict, or limit the selection of Airmen for assignment to or from certain duties or areas." *Total Force Assignments*, Department of the Air Force Instruction ("DAFI") 36-2110 ¶ 6.12 (15 Nov. 2021).

11. With respect to Airmen newly diagnosed with HIV, "HIV-infected [sic] members who have been evaluated for continued medical service and are retained will receive an Assignment Limitations Code-C (ALC-C)." AFI 44-178 ¶ A9.1.2.

12. The "C" stratification is an ALC subcategory.

> Medical Assignment Limitation Code "C" Stratification. When a Physical Evaluation Board determines an Airman to remain on active duty, who may not be fully qualified for worldwide service, the Air Force carefully manages future assignments. In such cases, AFPC/DP2NP will input and manage assignment limitation code "X" for C1 stratification, "Y" for C2 stratification, or "C' for C3 stratification … as appropriate for description, effective date and duration, and limitation on PCS [permanent change of station] selection.

DAFI 36-2110 ¶ 6.12.1. While Airmen with any "C" stratification require a medical waiver to qualify for a contingency deployment, it is my understanding that all Airmen with HIV are designated ALC-C2. Under the regulation, an ALC-C2 means that Airmen with HIV are assignable only to installations in the continental U.S. with intrinsic fixed medical treatment

facilities, or outside the continental U.S. only with the approval of the Surgeon General of the "gaining" major command (or delegate). *See* DAFI 36-2110, Table 3.2. Further, Airmen with HIV may not PCS outside of these limits without a waiver. *Id.*

13. Regardless of which "C" stratification an Airman with HIV receives, though—whether it is C1, C2, or C3—the code would classify them as non-deployable and assignment limited to specific installations.

14. In addition, because there have been no changes to DoD or Air Force deployment regulations, all Airmen with HIV are still required to obtain a medical waiver to deploy.

Army

15. Like the Air Force, the Army uses codes to indicate a Soldier's individual medical readiness and control their movement. In the Army, these codes are known as medical readiness classifications ("MRC") or MRC codes. *See Medical Readiness*, AR 40-502 ¶ 1-6 (27 June 2019). Medical readiness classifications range from 1 to 4, and "Commanders use the medical readiness information to determine if a Soldier is deployable and able to perform the unit's core designed mission or assigned mission … ." *Id.* ¶ 1-6(b).

16. Soldiers who are diagnosed with HIV have their "medical profile" coded in two ways: "the V code for deployment restrictions will be added to the profile, and medical nondeployment module changed to 'YES' by the HIV program coordinator." AR 600-110 ¶ 4-11(d); *see also id.* ¶ 4-13. Soldiers with HIV "will be limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands), *id.* ¶ 1-16(f), and the medical profile is designed to "allow[] commanders and medical personnel to track these individuals over time and ensure their continental United States ("CONUS") only duty status is not violated," *id.* ¶ 4-13(b).

17. As a result of the "V" code in the medical profile, a Soldier with HIV will be assigned an MRC 3, which means "not medically ready." *Medical Readiness Procedures*, Department of the Army Pamphlet ("DA PAM") 40-502 ¶ 1-6(c) & Table 1-2 (27 June 2019) (MRC 3 class includes individuals with deployment-limiting conditions for longer than 30 days, and listing deployment-limiting codes that include "[p]ermanent profiles with a deployment/ assignment restriction code (F, V, or X)").

18. Because there have been no changes to DoD or Army deployment regulations, all Soldiers with HIV are still required to obtain a medical waiver to deploy.

19. In addition, to my understanding, based on the MRC 3 classification, Soldiers with HIV may not even join units that *may* deploy (i.e., deployable units) unless they obtain an exception to policy ("ETP"). They are also required to obtain a waiver or ETP to change their Military Occupational Specialty ("MOS") to one that requires the Soldier to be deployment ready.

Navy

20. Unlike the Army and the Air Force, the Navy generally does not use special codes to track people with duty-limiting conditions. Instead, the Navy screens all Sailors at the time of PCS transfer to operational duty or when traveling overseas, and any unsuitability findings are handled then in accordance with applicable regulations. Those regulations are described below.

21. *Assignment of Active Duty Personnel with Bloodborne Pathogens (BBP)*, MILPERSMAN 1300-1300 (8 Nov 2021), outlines the assignment and distribution process for active duty Sailors with a "bloodborne pathogen" (BBP), which includes HIV. *Id.* ¶ 1. The process is as follows:

a. Upon initial diagnosis, a Sailor with HIV is placed on temporary limited duty ("TLD") and transferred to a medical unit for treatment. *Id.* ¶ 4.c(3). Upon "reaching stability," the Sailor then receives a medical assignment screening. *Id.* That medical screening is conducted under MILPERSMAN 1300-800, *Transfer of Personnel to Operational Duty (Operational Screening*) (14 Nov 2011).

b. Thereafter, just like any Sailor, Sailors with HIV who receive orders for operational duty or duty OCONUS, or who apply for PCS or reassignment OCONUS, undergo assignment screening. *E.g.*, MILPERSMAN 1300-1300 ¶ 5; *see generally* MILPERSMAN 1300-800; *Overseas/Remote Service General Information*, MILPERSMAN 1300-300 (6 Jul 2015).

c. During this screening process, Sailors with HIV are subject to additional screening, are subject to assignment limitations and restrictions, and may be found unsuitable for some orders or assignments. *E.g.*, MILPERSMAN 1300-1300 ¶ 6 (describing various responsibilities for clearing service members); *id.* ¶ 6.d(5) (noting that waivers are required for Sailors with HIV who are in "special communities" such as aviation or submarine duty). For example, for OCONUS or operational orders, Sailors with HIV are screened for assignment to eight commands/bases listed in Exhibit 1 to MILPERSMAN 1300-1300. *Id.* ¶ 5 & Ex. 1.

22. Of the policies described above, all were in place before the April 2022 Orders, and for each of them the provisions applicable to service members with HIV have not been modified since that time.

Recent Experiences of Service Members with HIV

23. Below, I describe the experiences of several service members with HIV in

navigating reassignment, deployment, or commissioning since the April 2022 Orders. I do not believe that Defendants dispute these facts. Nevertheless, should Defendants or the Court object to this manner of presenting these facts, Plaintiffs are willing to obtain affidavits from each of these witnesses at the Court's request.

24. I have anonymized the names of the service members below and generalized some of the details of their circumstances so as to preserve confidentiality. All of them are living with HIV, are asymptomatic, and have undetectable viral loads.

Service Members Restricted in Assignment and Deployability

25. Several service members have faced restrictions and barriers pertaining to assignment and deployment.

Army National Guard Sergeant A.J.

26. A.J. is a Sergeant (E-5) in a battalion of a state Army National Guard ("ARNG"). On December 26, 2022, SGT A.J.'s unit began its deployment to Saudi Arabia without him because his HIV status classified him as presumptively non-deployable.

27. SGT A.J.'s unit received deployment orders in mid-November 2022. Because an MRC flagged him as non-deployable, SGT A.J. had to go through the waiver process. With the support of his non-commissioned officer in charge ("NCOIC") and his unit commander, SGT A.J. prepared and submitted a waiver request to the ARNG waiver authority for approval and submission to Central Command ("CENTCOM").

28. On November 21, 2022, SGT A.J. was informed that he would not be able to deploy with his unit. According to SGT A.J., Medical Command ("MEDCOM") of the state ARNG had received word from CENTCOM that it would not approve a waiver for SGT A.J. After I became involved, however, the ARNG waiver authority changed its position and, in

accordance with MOD16, officially approved SGT A.J.'s waiver request for submission to and approval by CENTCOM.

29. CENTCOM denied the waiver. (The waiver denials are attached as Exhibit 8 to this declaration. According to communications from Defendants' counsel to me, the first page of Exhibit 8 is a recommended denial signed by Colonel Janet Chenault, Chief of Health Readiness at Army Central Command ("ARCENT"). According to Defendants' counsel, COL Chenault's recommendation was then sent to CENTCOM, where it was then denied as reflected in page two of the Exhibit.) In comments, the CENTCOM denial stated: "Meets USCENTCOM entry requirements for HIV, but Kuwait restricts those with HIV from entering the country. Per the US State Department on Kuwait: Some HIV/AIDS entry restrictions exist for visitors to and foreign residents of Kuwait. Residency permits require an HIV/AIDS test and permits may be denied if applicants test positive. If HIV-related illness becomes known, the resident must leave the country or be deported." (Ex. 8, at 2.)

30. Although the waiver was denied on December 5, the ARNG waiver authority did not notify SGT A.J.'s NCOIC of the denial until December 20—six days before the unit was scheduled to mobilize.

31. The denial focused on Kuwait, not Saudi Arabia, because the waiver request had indicated that Kuwait was SGT A.J.'s destination. (*See* Ex. 8.) In fact, Kuwait was merely a staging area: SGT A.J.'s unit would fly there, stay only for around a week or ten days, then proceed on to Saudi Arabia. I made Defendants' counsel aware of these facts during a call on December 22, 2022. Defendants' counsel subsequently informed me that if the ARNG re-submitted the waiver request indicating that SGT A.J.'s destination was Saudi Arabia, it likely would be granted.

32. SGT A.J. prepared and submitted another waiver request, listing Saudi Arabia as his destination, and sent it up to the ARNG waiver authority on December 27, the day after SGT A.J.'s unit mobilized without him. But the ARNG waiver authority did not immediately approve and sent it to CENTCOM. On January 11, 2023, I received a call from ARNG commanders about SGT A.J.'s situation. The commanders were reluctant to submit the second waiver to CENTCOM because they thought it would be denied: in their words, they had reviewed the State Department's travel guidance for Saudi Arabia and concluded that it was similar to the guidance for Kuwait, so they believed that the waiver would be denied on the same grounds. I assured the commanders that there must have been a reason why I had been assured that the waiver "likely" would be granted, and I urged them to approve and submit it. There was also an issue about getting SGT A.J. to Saudi Arabia without going through Kuwait, as CENTCOM's approval of the waiver was conditioned on getting SGT A.J. to Saudi Arabia without a brief stop in Kuwait.

33. On January 11, the ARNG waiver authority approved the waiver with a notation: "20230111 - FT. Hood MOB BDE [Mobility Brigade] states they can deploy SGT [A.J.] direct to Saudi Arabia without transition through Kuwait. I respectfully request second review of this waiver. Thank you, COL [Name]." COL Chenault approved this second waiver on January 11. (A copy of the approved waiver is attached to this declaration as Exhibit 9.)

34. But for my direct involvement in SGT A.J.'s situation—including the engagement of Defendants' counsel—and my advocacy for the submission and approval of his wavier request, it appears unlikely that his waiver would have been submitted, much less granted. Most service members with HIV, however, will not have the advantage of the involvement of a lawyer or personal ombudsman to facilitate their waiver requests under Defendants' system. Those who

do not have advocates helping them will likely be denied opportunities, like SGT A.J. almost was.

35. SGT A.J. mobilized to Ft. Bliss on January 25, long after his unit had already departed for the Middle East. He cleared medical on February 1, but for the next two weeks, SGT A.J. waited while the Army attempted to sort out confusion about his deployment. There were two issues: First, according to emails—true copies of which are attached to this declaration as Exhibit 10—military mobilization units responsible for transporting deploying units, under the belief that SGT A.J. was "not authorized to traverse through Qatar or Kuwait due to medical restriction," were trying to get approval to send SGT A.J. to Saudi Arabia by commercial airline. (Relatedly, there were disagreements about who was responsible for paying for this commercial flight.)

36. Second, Army regulations apply *accessions regulations* to members of the Reserves with HIV who receive active-duty orders and require approval of the Assistant Secretary of the Army (Manpower and Reserve Affairs) ("ASA(M&RA)") for orders lasting over 30 days.[1] SGT A.J. was informed on February 6 that he would need an ETP and ASA(M&RA) approval to join his unit in Saudi Arabia. (*See* Ex. 10.) The email conveying this news acknowledged the HIV Memo but felt constrained by the absence of new guidance: "The June 6th [HIV Memo] put out guidance for Soldiers with certain medical conditions can be deployable. But, until clarification guidance is approved, a Soldier must still complete the ETP packet with the Combatant Command's medical waiver in order to be considered for a

[1] *See* AR 600-110 ¶ 5-2(a)(7) (defining "accessions" to include "[p]eacetime orders of a RC [reserve component] to AD [active duty]"); *id.* ¶ 7-2(a) (applying accessions regulations to "[p]ersonnel ordered to AD for more than 30 days"); *id.* ¶ 7-2(b) ("the [ASA(M&R)] may authorize HIV infected [sic] RC Soldiers to be ordered ADOS [active duty for operational support]," the type of deployment to which SGT A.J. was being ordered).

deployment." (*See* Ex. 10.) Subsequently, it was decided that an ETP would not be required, and the Army could proceed on the basis of the HIV Memo.

37. SGT A.J. finally departed for Saudi Arabia on February 17, almost two months after his unit first mobilized. By then, his unit had been in Saudi Arabia for nearly three weeks, and they had trained and prepared for deployment without him since their initial December 26 mobilization. SGT A.J. missed out on these important aspects of a deployment, when a unit comes together, learns about their mission and roles, and prepares and trains as a whole.

Navy Petty Officer second class C.J.

38. C.J. is a Petty Officer Second Class (E-5) in the Navy, where he has served for over five years. Based on his HIV status, PO2 C.J. was denied a prestigious and highly coveted assignment for which he was otherwise qualified.

39. In 2021, PO2 C.J. applied for a special-duty billet in the Defense Courier service ("DCS"). He subsequently passed the medical screening, completed financial counseling requirements, and received "Top Secret" clearance. PO2 C.J. had several options for assignment and asked to be stationed in Sicily, at the U.S. Naval Air Station Sigonella.

40. The current BBP Regulation—MILPERSMAN 1300-1300, discussed above—contains a list of commands eligible for overseas or operational assignment of members with bloodborne pathogens. *See* MILPERSMAN 1300-1330, at Ex. 1. The list notes that the Naval Hospital in Sigonella, Italy had medical facilities capable of providing services to Sailors with BBP. So under existing regulations, Sicily was an acceptable overseas assignment for Sailors with HIV, including PO2 C.J.

41. When it came time for his detailer to cut orders, however, PO2 C.J. was flagged for medical reasons—specifically HIV. At that point, an officer in Navy Personnel Command

became involved, likely due to the additional screening imposed on Sailors with HIV (discussed above). That officer, Lieutenant Commander Ryan Peterson, informed PO2 C.J. that the job might require him to deliver mail into Bahrain and Iran and claimed that such travel was not permitted due to PO2 C.J.'s HIV status.

42. PO2 C.J. made LCDR Peterson aware of the HIV Memo, but that did not change anything. In an email addressing the Memo, LCDR Peterson wrote: "As things are now yes, you are deployable. But currently per MILPERSMAN 1300-1300 that is limited to platforms with a fulltime medical officer assigned to it. … We'll see if that changes when the new [Navy] instruction is released." (A true copy of this email exchange is attached as Exhibit 11.)

43. When PO2 C.J. pointed out that he had previously traveled on military papers into Bahrain and even had liberty there, LCDR Peterson said he "didn't want to hear that" and reiterated that he and the detailer no longer supported PO2 C.J.'s placement in the billet. PO2 C.J. tried again to convince LCDR Peterson by asking if the assignments requiring travel through Bahrain and Iran could be swapped to other couriers in the billet, but LCDR Peterson again shut him down, saying it was "just too much risk." The "risk," as it was explained to PO2 C.J., was that he would be detained in one of these countries for an extended period, without access to his medication.

44. PO2 C.J. did not want to miss his rotation date, so he accepted a less attractive post in a stateside billet. PO2 C.J. was not offered an opportunity to seek a waiver for the coveted assignment until after I made inquiries on his behalf. (A true copy of an email to me from Defendants' counsel concerning PO2 C.J. and the waiver offer is attached to this declaration as Exhibit 12.) By then, however, PO2 C.J. had already accepted his new, less desirable assignment.

Army First Lieutenant B.J.

45. B.J. is a First Lieutenant (O-2) in the Army. As he was finishing his first assignment last year and looking for a new tour of duty, 1LT B.J. was prevented from joining deployable units because his MRC classifies him as non-deployable due to HIV.

46. 1LT B.J. recently completed an Army commissioning program and in late 2022 his initial post-graduation assignment was coming to an end. His career manager advised 1LT B.J. that, to advance his career, he needed to be assigned to a deployable unit. Accordingly, 1LT B.J. tried applying to several available assignments to deployable units, but he found that he could not get interviews for these open positions because of his MRC classified him as non-deployable.

47. To address this roadblock, 1LT B.J. spoke to Anthony B. Clark, Chief, Policy Procedures & Special Actions Branch of Army HRC. Mr. Clark confirmed awareness of the new DoD policies governing the deployability of service members with HIV, but he informed 1LT B.J. via email that "even though the policy has changed, the policy is still the same." Mr. Clark further told 1LT B.J. that the Army "will not change" how it applies MRC classifications for soldiers with HIV.

48. 1LT B.J. also spoke to numerous people at Army HRC—including MSG Teddy Lee Fain III, the HRC Surgeon Sr. Medical NCO, and MAJ Stephanie Gasper, HRC Career Manager for 1LT B.J.'s career field—to work through these issues, but those discussions did not resolve the issue.

49. To overcome the MRC classification marking him as non-deployable, Mr. Clark advised 1LT B.J. that he needed to seek an ETP to be considered for an assignment to a

deployable unit. But an ETP would have taken at least 90 days to process, long after 1LT B.J.'s assignment cycle would close and available placements would be filled.

50. 1LT B.J.'s deadline to apply for positions ended in mid-November without resolution of this issue. He accepted a new, less desirable assignment, in a role outside of his primary interest, in a non-deployable unit.

First Sergeant E.J.

51. E.J. is a First Sergeant (E-8) in the Army. After Defendant Austin issued the HIV Memo in June 2022, 1SG E.J.—like many Soldiers with HIV—expected that the Army would update its policies, including AR 600-110, as instructed in the HIV Memo. On July 31, 2022, curious about how Army policies were changing, 1SG E.J. sent an email inquiry to Army HRC with a copy of the HIV Memo: "I am curious with the new update to the HIV policy (attached), are Soldiers now allowed to be slotted in MTOE positions?" (A true copy of this email string is attached to this declaration as Exhibit 13.) MTOE stands for Modification Table of Organizational Equipment, which in general terms is a standardized listing of authorized equipment and staff of any Army unit. In practical terms, an MTOE unit is a deployable unit; it means that all personnel in the unit are military, and that the unit can deploy anywhere in the world at any time.

52. 1SG E.J. received a response the next day from personnel at Army HRC. The response stated: "Unfortunately to the best of my knowledge the [HIV Memo] doesn't change our current practices." (Ex. 13.) The email response listed the "general rules" for assignment of Soldiers with HIV:

> 1. Assign to CONUS, [Alaska], [Hawaii] only.
> 2. No OCONUS (SOFA agreements and pain/political factors)
> 3. Assign to TDA when possible. Some MOS [military occupational specialties] are only authorized in MTOE units. We assign to MTOE at

> the [Brigade] level or higher as commanders determine "who" they are going to deploy.
> 4. The attached [HIV Memo] will not affect how we assign that population. (Ex. 13.)

TDA refers to Tables of Distribution of Allowance; as compared to MTOE units, TDA units are non-deployable units and may contain civilians and contractors. In essence, point number 3 in the email to 1SG E.J. meant that Brigade Commanders who are forming MTOE units will not include Soldiers with HIV as they decide "who" they are going to deploy and thus who joins their Brigade.

53. Notably, according to the email to 1SG E.J., the Army still justified classifying Soldiers with HIV as non-deployable based on "SOFA agreements," which this Court previously rejected as an unsupported justification for the deployment ban it struck down in the April 2022 Orders.

54. 1SG E.J. sent a follow-up email to Army HRC: "My big question is can we be assigned to a MTOE unit in the [United States] and it be up to the medical team on whether or not we can deploy? If I understand you correctly, we can as long as it is a BDE level billet or higher?" (Ex. 13.) Stated another way, 1SG E.J. wanted to know if Soldiers with HIV could join a stateside MTOE unit and then, in the event of a deployment, ask Brigade commanders to deploy them—consistent with the HIV Memo.

55. In response, Army HRC confirmed the restrictions that continue to exist for all Soldiers with HIV:

> 1SG[,] HIV Soldier[s] are not deployable. We reassign to MOTE unit at BDE or higher because the units typically do not deploy as a whole, but as a slice. Therefore that SM would be and could be moved to another unit not in a deployment cycle. Soldiers cannot be reassigned OCONUS except to Alaska or Hawaii, due to SOFA agreement. Currently the only way a Soldier can go OCONUS is as an approved ETP by MEDCOM. I hope this clarifies a little better. (Ex. 13.)

56. In sum, these stories demonstrate that the military departments are treating service members with HIV in the same manner now as they were before the April 2022 Orders.

Enlisted Members Attempting to Commission

57. As the Court will recall, before these lawsuits, Defendants applied accession standards to enlisted service members with HIV who wanted to directly commission (like plaintiff Nick Harrison) or to enter a commissioning program. Until the April 2022 Orders, accession standards disqualified service members with HIV from commissioning.

58. As a result of the April 2022 Orders, the accessions regulation, as it pertains to HIV, now reads as follows:

> Presence of human immunodeficiency virus or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s) is not, in itself, disqualifying with respect to covered personnel (including Military Service Academy cadets and midshipmen, contracted Senior Reserve Officers' Training Corps cadets and midshipmen, and other participants in in-service commissioning programs) seeking to commission while a Service member. Such covered personnel will be evaluated on a case-by-case basis. (Ex. 2, DoDI 6130.03, Vol. 1 ¶ 5.23(b).)

"Covered personnel" is defined in a different section of the regulation, but the definition is consistent with the April 2022 Orders: "Individuals who have been identified as HIV positive, are asymptomatic, and who have a clinically confirmed undetectable viral load." (Ex. 2. Section G.2, Definitions.) The language requiring "covered personnel" to be "evaluated on a case-by-case basis" is unique to service members with HIV; such language does not apply to any other condition in the regulation.

59. Further, the "General Issuance Information" section of the accessions regulation, which summarizes the changes each time a regulation is reissued, states that covered personnel "will have no restrictions applied to their deployability or to their ability to commission … solely on the basis of their HIV-positive status." (Ex. 2, DoDI 6130.03, Vol. 1 ¶ 1.4.)

60. Despite this language in Paragraph 1.4, the experiences of service members with HIV, detailed below, demonstrate that there are in fact "restrictions applied to their deployability or to their ability to commission."

61. According to information I have received from affected enlisted members, they are being required to prepare and submit a medical waiver as part of any application to enter a commissioning program or directly commission from enlisted ranks.

Sergeant First Class D.J.

62. D.J. is a Sergeant First Class (E-7) in the Army, in which he has served for over 15 years. All of SFC D.J.'s Army experience has been in medical fields or roles. After completing his bachelor's degree while in service, SFC D.J. desired to continue his service in the medical field but is facing potential restrictions based on his non-deployable MRC classification.

63. Specifically, SFC D.J. wanted to enter the Enlisted to Medical Degree Preparatory Program ("EMDP2"), a two-year, full-time education program for enlisted service members that leads to a pre-med undergraduate certificate. Successful completion of the EMDP2 program would lead to a commission as an Army officer and, typically, admission to medical school.

64. To complete his EMDP2 application, SFC D.J. was required to submit to the admissions committee a Soldier Record Brief ("SRB"), which contains his MRC. Because of his HIV status, SFC D.J.'s MRC classifies him as non-deployable despite the injunctions of this Court. An MRC 3 classification of non-deployable is disqualifying for programs like EMDP2, because service members who are non-deployable are unable to commission.

65. Concerned that his HIV status and MRC code would interfere with his application to the EMDP2, SFC D.J. reached out by email to representatives in the Army's Office of the

Deputy Chief of Staff for Personnel ("Army G-1"). SFC D.J. attached a copy of Defendant Austin's HIV Memo and asked:

> I was wondering how the Attached DOD Directive changes the policy outlined [in] AR 600-110 for accessions physicals and the exception to policy process? I will be applying to the Enlisted to medical degree program through USUHS and wanted to ensure that there is no issue as I proceed through this process. My HIV Program Manager didn't know and suggested I do an ETP however the ETP timeline will not work with the application timeline as the application must be submitted by 30 September 2022 with a conditional release from my branch. (Ex. 14, at 2.)

A true copy of this email exchange is attached as Exhibit 14.

66. In an email response, SFC D.J. was instructed to follow the ETP process, indicating that Army policy had not changed (although it was under review):

> Thanks for your email. The Army is participating in a DoD [working group] to address the issues highlighted in the [HIV Memo].
>
> For your ETP request, we are happy to support any questions you have and highly recommend you submit as early as possible if you intend to apply. I understand the confidentiality and privacy concerns, but I would ask for you to inquire (as generally as you can) if you can apply without having the ETP. I have heard of programs that will do the ETP once you have been accepted into the program. (Ex. 14, at 1.)

67. SFC D.J. applied to EMDP2 and included in his application a request for an exception to the Army's unchanged policy, reflected in AR 600-110, that barred people with HIV from commissioning.

68. SFC D.J. subsequently learned that his ETP for HIV was granted. But future service members with HIV who apply to commissioning programs like EMDP2 will still need to request a waiver and face the prospect that it could be denied, and their applications rejected, due to their HIV status. To my understanding, Defendants believe that this treatment of service members with HIV complies with the April 2022 Orders—and would still comply if the HIV medical waiver were denied.

Sergeant Nick Harrison

69. One of the members affected by this policy is Sergeant Nick Harrison, the plaintiff in *Harrison v. Austin*. Though the Court's April Order in *Harrison v. Austin* required Defendants to "reevaluate" SGT Harrison's application, Defendants claimed they could not do so because it had been destroyed, and they believed that simply updating it would have been insufficient. Defendants made SGT Harrison reapply—which required him to reassemble all of the necessary materials—and secure a medical waiver.

70. With SGT Harrison's enlistment term set to expire in late June 2022, Defendants offered a six-month extension to his service commitment—to January 2023—and suggested that a decision would be reached by then. SGT Harrison submitted his application in August 2022, and provided additional material—at the Army's then-urgent request—in late November. But when late January 2023 came, SGT Harrison learned that there had been no decision on his application. Defendants provided no time frame for completing the process but, at the request of counsel, agreed to extend SGT Harrison's service commitment for yet another six months, to June 2023.

71. Though SGT Harrison was informed in September 2022 that his age waiver had been granted, as of March 2023 he had not been informed whether his medical waiver for HIV had been granted.

72. On April 6, 2023, a full year after the Court ruled in his favor and required Defendants to reevaluate his application, SGT Harrison finally was notified that he was being recommended for appointment as a First Lieutenant in the Judge Advocate General Corps of the District of Columbia National Guard. The commission SGT Harrison has been offered is for appointment at the rank of First Lieutenant (O-2)—but in 2014, at the time of his initial

application, his superiors had suggested that, based on his experience and qualifications, he likely would have received a higher rank (Captain (O-3)). In addition, SGT Harrison was informed that if he accepted the commission, he would be obligated to serve for another eight years, even though he became eligible for retirement in 2022.

Discussions with Defendants and Meet-and-Confer on the Motion

73. Plaintiffs' counsel have been discussing the deficiencies in Defendants' response to the Court's April 2022 Orders since shortly after Defendant Austin issued the HIV Memo.

74. On July 1, 2022, Plaintiffs' counsel sent Defendants a letter highlighting how Defendants' changes to the medical standards regulations (DoDI 6130.03) and HIV regulation (DoDI 6485.01) did not comply with the Court's April 2022 Orders—even when read in light of the HIV Memo. (A copy of that letter is attached to this declaration as Exhibit 15.) That letter led to at least one telephonic discussion among counsel for the parties.

75. In the fall of 2022, I started to hear from service members with HIV who continued to be negatively affected by Defendants' HIV policies, including the service members discussed above. Learning of these problems prompted me to prepare and send a letter to Defendants' counsel on November 22, 2022, a copy of which is attached to this declaration as Exhibit 16. The letter notified Defendants of the problems that the service members above were facing and also argued that Defendants' waiver system created systemic problems for service members with HIV that caused Defendants to be out of compliance with the April 2022 Orders.

76. On December 9, 2022, counsel for the parties held a telephonic meet-and-confer to discuss the issues raised in the November letter. Defendants' counsel had no updates on the specific circumstances of the service members raised in the letter. Defendants' counsel disagreed that Defendants were implementing the Court's injunctions in a manner contrary to the April

2022 Orders. Defendants' counsel also stated that Defendants were working on broader policy guidance about how to implement the HIV Memo, claiming that there was a draft that had been circulated that was still undergoing review by relevant stakeholders. Defendants' counsel did not have a timeline for release of that broader policy guidance but said "hopefully soon." Over four months later, however, such guidance has not been issued.

77. On December 20, after receiving word that SGT A.J.'s first waiver had been denied, I sent another email to Defendants' counsel informing them of the ways in which the waiver denial itself failed to comply with the April 2022 Orders. A copy of that email is attached as Exhibit 17.

78. On December 22, Defendants' counsel responded by email. A copy of this email is attached as Exhibit 18. In the email, Defendants' counsel admitted that "the military's downstream implementation of the [June 6] policy memorandum [was] still ongoing," and policies on HIV "remain in flux." Nevertheless, counsel continued to maintain that Defendants were in compliance with the April 2022 Orders because "the military does not employ [a] categorical bar." (Ex. 18.)

79. Counsel's December 22 email also included a copy of a CENTCOM waiver that had been granted. A true copy of this waiver, as received from counsel, is attached as Exhibit 19. The waiver indicated Iraq as the destination, and the subject was a civilian. CENTCOM approved the waiver with the following note: "HIV/AIDS: Iraq imposed HIV/AIDS-related travel restrictions on all visitors and new residents. Travelers should verify their eligibility to travel to Iraq with the Embassy of Iraq before traveling. [¶] HIV … meets USCENTCOM requirements, but it is unknown if individual will be allowed in country based on state department information. Given lack of concrete information on ability to enter Iraq, waiver

approved." This waiver approval shows the inconsistency of CENTCOM waiver decisions for HIV: as compared to SGT A.J.'s first waiver request (for Kuwait), the State Department guidance for Iraq is worse. Yet CENTCOM granted the waiver anyway. For SGT A.J., CENTCOM wouldn't even allow him to travel *through* Kuwait.

80. My efforts to assist 1LT B.J. and PO2 C.J. were unsuccessful, and the circumstances were irreversible by the end of December. By mid-February, SGT A.J.'s situation resolved when he finally joined his unit in Saudi Arabia. With those individual matters no longer emergent, Plaintiffs' counsel focused on preparing the memorandum in support of the motion to which this declaration is attached. On April 5, 2023, the parties held another meet-and-confer teleconference during which Plaintiffs' counsel re-iterated their intention to bring to the Court's attention the systemic issues leading to non-compliance with the April 2022 Orders through a motion to enforce and order to show cause why Defendants should not be held in contempt.

81. On April 10, 2023, Defendants' counsel provided a formal written response, which is attached to this declaration as Exhibit 20. In it, Defendants reiterated their position that they are in full compliance with the April 2022 Orders and declined to commit to any changes to internal regulations or procedures for making decisions with respect to "whether" (not "how") service members living with HIV can be approved for deployment, commissioning, or other activities.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 3rd day of May, 2023.

Peter Perkowski

Exhibit 1

HIV Memo

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

JUN 0 6 2022

MEMORANDUM FOR SENIOR PENTAGON LEADERSHIP
COMMANDERS OF THE COMBATANT COMMANDS
DEFENSE AGENCY AND DOD FIELD ACTIVITY DIRECTORS

SUBJECT: Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces

In view of significant advances in the diagnosis, treatment, and prevention of Human Immunodeficiency Virus (HIV), it is necessary to update DoD policy with respect to individuals who have been identified as HIV-positive. Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load (hereinafter, "covered personnel") will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV-positive status. This definition of "covered personnel" will be added to the affected DoD Instructions.

Accordingly, effective immediately I direct the following actions:

- Accession:
  - DoD Instruction 6130.03, "Medical Standards for Military Service: Appointment, Enlistment, or Induction," volume 1, section 5: Disqualifying Conditions, 5.23.b., is revised by adding the following language in boldface: "Presence of human immunodeficiency virus or laboratory evidence of infection for false-positive screening test(s) with ambiguous results by supplemental confirmation test(s) **is not, in itself, disqualifying with respect to covered personnel (including Military Service Academy cadets and midshipmen, contracted SROTC cadets and midshipmen, and other participants in in-service commissioning programs) seeking to commission while a Service member). Such covered personnel will be evaluated on a case-by-case basis."**
  - DoD Instruction 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," section 3.a., is revised to read: "It is DoD policy to . . . Deny eligibility for Military Service to persons with laboratory evidence of HIV infection for appointment (**other than covered personnel who are seeking to commission while a Service member**), enlistment, pre-appointment, or initial entry training for Military Service pursuant to DoDI 6130.03."
- Retention: DoD Instruction 6130.03, "Medical Standards for Military Service: Retention," volume 2, section 5.23.b.(1), is revised by adding the following language in boldface: "A Service member with laboratory evidence of Human Immunodeficiency Virus infection will

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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, **including evaluation on a case-by-case basis. Covered personnel will not be discharged or separated solely on the basis of their HIV-positive status.**

- Deployability: Covered personnel are not non-deployable solely for the reason that they are HIV-positive. Decisions on the deployability of covered personnel will be made on a case-by-case basis and must be justified by the Service member's inability to perform the duties to which he or she would be assigned. DoD Instruction 1332.45, "Retention Determinations for Non-Deployable Service Members," will be implemented consistent with this direction.

- The Director of Administration and Management will make the revisions directed above in the cited DoD Instructions.

- The Under Secretary of Defense for Personnel and Readiness will convene a working group, chaired by his designee and composed of members named by himself, the Secretaries of the Military Departments, the Chairman of the Joint Chiefs of Staff, the Office of the Secretary of Defense, and the General Counsel of the DoD. The working group shall:

  - Develop proposed standards for conducting the case-by-case determinations directed above. Included in such standards will be the period during which, and method by which, covered personnel must exhibit an undetectable viral load and be symptom free. The Under Secretary of Defense for Personnel and Readiness will report those proposed standards to me within six months from the date of this memorandum.

  - Consider such additional matters as may be referred to it by the Under Secretary of Defense for Personnel and Readiness.

- The Secretaries of the Military Departments and the Commanders of the Combatant Commands, will, as necessary, revise their respective regulations, policies, and other guidance consistent with this memorandum and no later than 60 days from the date of this memorandum.

- The Secretaries of the Military Departments will report to the Under Secretary of Defense for Personnel and Readiness on a semi-annual basis beginning six months from the date of this memorandum: (1) the number of HIV-positive Service members in their respective Services who have been separated; and (2) the number of HIV-positive individuals, who are asymptomatic with a clinically confirmed undetectable viral load, and who have been refused accession.

Exhibit 2A

DoDI 6130.03, Vol. 1

(June 6, 2022)

DoD INSTRUCTION 6130.03, VOLUME 1

MEDICAL STANDARDS FOR MILITARY SERVICE: APPOINTMENT, ENLISTMENT, OR INDUCTION

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective:	May 6, 2018
Change 3 Effective:	June 6, 2022
Releasability:	Cleared for public release. Available on the Directives Division Website at https://www.esd.whs.mil/DD/.
Reissues and Cancels:	DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
Approved by:	Robert L. Wilkie, Under Secretary of Defense for Personnel and Readiness
Change 3 Approved by:	Lloyd J. Austin III, Secretary of Defense

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Purpose: This instruction is composed of two volumes, each containing its own purpose. In accordance with the authority in DoD Directive 5124.02:

- This instruction establishes policy, assigns responsibilities, and prescribes procedures for medical standards for the Military Services.
- This volume establishes physical and medical standards for appointment, enlistment, or induction into the Military Services.

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This volume 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 Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

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

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

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

1.2. POLICY.

It is DoD policy to:

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

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

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

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

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

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

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

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

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

1.3. INFORMATION COLLECTIONS.

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

1.4. SUMMARY OF CHANGE 3.

In accordance with the June 6, 2022 Secretary of Defense Memorandum, the changes to this issuance update DoD policy with respect to individuals who have been identified as HIV positive. Individuals who have been identified as HIV positive, are asymptomatic, and who have a clinically confirmed undetectable viral load will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV positive status.

SECTION 2: RESPONSIBILITIES

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

The USD(P&R):

a. Ensures that the standards in Sections 4 and 5 are implemented throughout the DoD Components.

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

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

2.2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)).

Under the authority, direction, and control of the USD(P&R), the ASD(HA):

a. Reviews, approves, and issues technical modifications to the standards in Sections 4 and 5 to the Secretaries of the Military Departments.

b. Provides guidance to the DoD Medical Examination Review Board to implement the standards in Sections 4 and 5.

2.3. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD.

The Secretaries of the Military Departments and the Commandant, United States Coast Guard:

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

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

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

d. Ensure that medical information for “Existed Prior to Service” (EPTS) discharges is provided to the U.S. Military Entrance Processing Command by Service training centers conducting basic military training. Medical information will include:

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

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

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

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

2.4. SECRETARY OF THE NAVY.

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

SECTION 3: MEDPERS

3.1. ORGANIZATION.

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

3.2. AGENDA.

The MEDPERS:

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

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

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

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

4.1. APPLICABILITY.

The medical standards in this volume apply to:

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

b. Applicants for enlistment in the Military Services. For medical conditions or defects that predate the current enlistment and were not aggravated in the line of duty during the current enlistment, these standards apply to enlistees during the first 6 months of the current period of active duty.

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

d. Applicants for re-accession in Regular and Reserve Components and in federally recognized units or organizations of the National Guard after a period of more than 12 months have elapsed since the date on their DD Form 214, "Certificate of Release or Discharge from Active Duty," or separation orders, as applicable.

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

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

g. Individuals on the Temporary Disability Retired List who have been found fit when reevaluated by the Disability Evaluation System and who elect to return to active duty or to active status in the Reserve Components within the time standards prescribed by Service regulations. These individuals are exempt from the procedures in this volume only for the conditions for which they were found fit on reevaluation by the Disability Evaluation System. Applicants must meet all other medical standards contained in this section with the exception of the medical condition for which they were placed on the Temporary Disability Retired List.

h. All individuals being inducted into the Military Services.

4.2. PROCEDURES.

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

(1) Fully disclose all medical history.

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

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

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

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

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

(5) Acknowledge that any cadet or midshipman, whether contracted or noncontracted, who has a change in medical status that is related to a standard in this regulation, understands that the change may disqualify them and that they will require an evaluation or physical prior to determining accession qualifications.

b. The U.S. Military Entrance Processing Command and DoD Medical Examination Review Board will:

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

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

c. The DoD Components:

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

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

SECTION 5: DISQUALIFYING CONDITIONS

5.1. MEDICAL STANDARDS.

Unless otherwise stipulated, the conditions listed in this section are those that do **not** meet the standard by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment, or induction into the Military Services are classified into general systems in Paragraphs 5.2. through 5.30.

5.2. HEAD.

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

b. Loss, or absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving any residual defect in excess of 1 square inch (6.45 square centimeters), or the size of a U.S. quarter coin.

5.3. EYES.

a. Lids.

(1) Current symptomatic blepharitis.

(2) Current blepharospasm.

(3) Current dacryocystitis, acute or chronic.

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

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

b. Conjunctiva.

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

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

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

c. Cornea.

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

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

(3) Corneal refractive surgery performed with an excimer or femtosecond laser, including but not limited to photorefractive keratectomy, laser epithelial keratomileusis, laser-assisted in situ keratomileusis, and small incision lenticule extraction, if any of the following conditions are met:

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

(b) Pre-surgical astigmatism exceeded 3.00 diopters.

(c) Within 180 days of accession medical examination.

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

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

(4) Current or recurrent keratitis.

(5) History of herpes simplex virus keratitis.

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

(7) Any history of uveitis or iridocyclitis.

d. Retina.

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

e. Optic Nerve.

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

(2) Any optic nerve anomaly.

f. Lens.

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

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

g. Ocular Mobility and Motility.

(1) Current or recurrent diplopia.

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

(3) Esotropia, exotropia, and hypertropia.

(4) History of restrictive ophthalmopathies.

h. Miscellaneous Defects and Diseases.

(1) History of abnormal visual fields.

(2) Absence of an eye.

(3) History of disorders of globe.

(4) Current unilateral or bilateral exophthalmoses.

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

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

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

(8) Current night blindness.

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

(10) History of ocular tumors.

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

5.4. VISION.

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

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

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

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

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

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

5.5. EARS.

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

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

c. History of any surgically implanted hearing device.

d. History of cholesteatoma.

e. History of any inner or middle ear surgery.

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

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

5.6. HEARING.

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

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

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

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

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

c. History of using hearing aids.

5.7. NOSE, SINUSES, MOUTH, AND LARYNX.

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

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

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

d. Current olfactory deficit.

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

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

g. Current symptomatic perforation of nasal septum.

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

5.8. DENTAL.

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

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

c. Current severe malocclusion, which interferes with normal chewing or requires immediate and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement.

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

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

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

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

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

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

5.9. NECK.

a. Current symptomatic cervical ribs.

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

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

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

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

b. Current abscess of the lung or mediastinum.

c. Infectious pneumonia within the last 3 months.

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

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

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

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

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

g. Bronchiectasis (after the 1st birthday).

h. Bronchopleural fistula, unless resolved with no sequelae.

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

j. History of empyema unless resolved with no sequelae.

k. Interstitial lung disease including pulmonary fibrosis.

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

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

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

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

p. Recurrent spontaneous pneumothorax.

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

r. Tuberculosis:

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

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

s. History of pulmonary or systemic embolus.

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

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

5.11. HEART.

a. History of valvular repair or replacement.

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

(1) Moderate or severe pulmonic regurgitation.

(2) Moderate or severe tricuspid regurgitation.

(3) Moderate or severe mitral regurgitation.

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

(5) Mitral valve prolapse associated with:

(a) Mild or greater mitral regurgitation.

(b) Cardiopulmonary symptoms.

(c) Medical therapy specifically for this condition.

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

d. All valvular stenosis.

e. History of atherosclerotic coronary artery disease.

f. History of pacemaker or defibrillator implantation.

g. History of supraventricular tachycardia if:

(1) History of atrial fibrillation or flutter.

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

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

i. The following abnormal electrocardiograph patterns:

(1) Long QT.

(2) Brugada pattern.

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

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

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

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

(1) Sinus arrhythmia.

(2) First degree AV block.

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

(4) Early repolarization.

(5) Incomplete right bundle branch block.

(6) Wandering atrial pacemaker or ectopic atrial rhythm.

(7) Sinus bradycardia.

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

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

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

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

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

q. History of recurrent myocarditis or pericarditis.

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

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

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

(2) Ligated or occluded patent ductus arteriosus.

(3) Corrected atrial septal defect without residua.

(4) Patent foramen ovale.

(5) Corrected ventricular septal defect without residua.

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

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

v. History of Postural Orthostatic Tachycardia Syndrome.

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

5.12. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

a. Esophageal Disease.

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

(a) Stricture.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagus.

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

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

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

(4) History of eosinophilic esophagitis.

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

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

b. Stomach and Duodenum.

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

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

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

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

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

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

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

(6) History of gastric varices.

c. Small and Large Intestine.

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

(2) Current infectious colitis.

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

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

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

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

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

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

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

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

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

d. Hepatic-Biliary Tract.

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

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

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

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

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

(6) History of sphincter of Oddi dysfunction.

(7) History of choledochal cyst.

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

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

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

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

e. Pancreas.

History of:

(1) Pancreatic insufficiency.

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

(3) Chronic pancreatitis.

(4) Pancreatic cyst or pseudocyst.

(5) Pancreatic surgery.

f. Anorectal.

(1) Current anal fissure or anal fistula.

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

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

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

g. Abdominal Wall.

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

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

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

5.13. FEMALE GENITAL SYSTEM.

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

b. Primary amenorrhea.

c. Current unexplained secondary amenorrhea.

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

e. History of symptomatic endometriosis.

f. History of major abnormalities or defects of the genitalia including, but not limited to:

(1) Hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.

(2) A history of sex reassignment or genital reconstruction surgery is disqualifying unless all of the following conditions are met, as certified by a licensed medical provider:

(a) A period of 18 months has elapsed since the date of the most recent of any such surgery.

(b) No functional limitations or complications persist, and no additional surgery is required.

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

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

i. Pelvic inflammatory disease within the preceding 6 months.

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

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

l. Uterine enlargement due to any cause.

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

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

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

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

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

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

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

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

5.14. MALE GENITAL SYSTEM.

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

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

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

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

e. Current varicocele, unless it is:

(1) On the left side only.

(2) Asymptomatic and smaller than the testes.

(3) Reducible.

(4) Without associated testicular atrophy.

f. Current or history of recurrent orchitis or epididymitis.

g. History of penis amputation.

h. Current penile curvature if associated with pain.

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

(1) Current lesions are present;

(2) Use of chronic suppressive therapy is needed;

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

(4) Any outbreak in the past 12 months interfered with normal activities; or

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

j. History of urethral condyloma acuminatum.

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

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

m. History of major abnormalities or defects of the genitalia including, but not limited to:

(1) Hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.

(2) A history of sex reassignment or genital reconstruction surgery is disqualifying unless all of the following conditions are met, as certified by a licensed medical provider:

(a) A period of 18 months has elapsed since the date of the most recent of any such surgery.

(b) No functional limitations or complications persist, and no additional surgery is required.

5.15. URINARY SYSTEM.

a. History of interstitial cystitis or painful bladder syndrome.

b. Lower urinary tract infection (cystitis):

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

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

c. Current urethritis.

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

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

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

(3) Enuresis.

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

(5) Urinary retention.

(6) Dysuria.

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

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

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

(1) Gross hematuria.

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

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

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

i. Absence of one kidney, congenital or acquired.

j. Asymmetry in size or function of kidneys.

k. History of renal transplant.

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

m. History of polycystic kidney.

n. History of horseshoe kidney.

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

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

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

(2) Casturia; or

(3) Abnormal renal biopsy.

q. History of acute kidney injury requiring dialysis.

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

s. Urolithiasis if any of the following apply:

(1) Current stone of 3 mm or greater.

(2) Current multiple stones of any size.

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

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

(5) History of urolithiasis requiring a procedure.

5.16. SPINE AND SACROILIAC JOINT CONDITIONS.

a. Ankylosing spondylitis or other inflammatory spondylopathies.

b. History of any condition, in the last 2 years, or any recurrence, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:

(1) It prevents the individual from successfully following a physically active avocation in civilian life, or is associated with local or radicular pain, muscular spasms, postural deformities, or limitation in motion;

(2) It requires external support;

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

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

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

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

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

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

(3) It is symptomatic; or

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

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

e. Current dislocation of the vertebra.

f. Vertebral fractures including but not limited to:

(1) Any cervical spine fracture.

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

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

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

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

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

j. Spinal dysraphisms other than spina bifida occulta.

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

5.17. UPPER EXTREMITY CONDITIONS.

a. Limitation of Motion.

Current active joint ranges of motion less than:

(1) Shoulder.

(a) Forward elevation to 130 degrees.

(b) 130 degrees abduction.

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

(d) Cross body reaching 115 degrees adduction.

(2) Elbow.

(a) Flexion to 130 degrees.

(b) Extension to 30 degrees.

(3) Wrist.

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

(4) Hand.

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and Thumb.

Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Fingers.

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

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

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

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

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

(6) Current polydactyly or syndactyly.

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

c. Residual Weakness and Pain.

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

5.18. LOWER EXTREMITY CONDITIONS.

a. General.

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

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

b. Limitation of Motion.

Current active joint ranges of motion less than:

(1) Hip.

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

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

(d) Abduction to 45 degrees.

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

(2) Knee.

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle.

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle.

(1) Current absence of a foot or any portion thereof, other than absence of a single lesser toe that is asymptomatic and does not impair function of the foot.

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

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

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

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

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

(7) Current or recurrent plantar fasciitis.

(8) Symptomatic neuroma.

d. Leg, Knee, Thigh, and Hip.

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

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

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

(4) Recurrent anterior cruciate ligament reconstruction.

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

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

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

(8) Meniscal transplant.

(9) Symptomatic medial and lateral collateral ligament instability.

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

(11) History of hip dislocation.

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

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

5.19. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES.

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

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

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

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

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

f. Fractures, if:

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

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

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

h. History of contusion of bone or joint if:

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

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

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

(4) The contusion requires frequent or prolonged treatment.

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

j. History of hip arthroscopy or femoral acetabular impingement.

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

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

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

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

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

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

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

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

s. History of osteonecrosis of any bone.

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

5.20. VASCULAR SYSTEM.

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

b. Current or medically-managed hypertension. Hypertension is defined as systolic pressure greater than 140 millimeters of mercury (mmHg) or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure cuff averaged over two or more properly measured, seated, blood pressure readings on separate days within a 5-day period (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 separate days within a 5-day period).

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

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

e. History of deep venous thrombosis.

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

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

5.21. SKIN AND SOFT TISSUE CONDITIONS.

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

b. Severe nodulocystic acne, on or off antibiotics.

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

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

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

f. Cysts, if:

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

(2) The current pilonidal cyst is associated with a tumor mass or discharging sinus, or is a surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-

operative. A pilonidal cyst that has been simply incised and drained does not meet the military accession medical entrance standard.

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

h. Current or chronic lymphedema.

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

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

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

l. History of severe keloid formation.

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

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

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

p. History of photosensitivity, including but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus, porphyria, and xeroderma pigmentosa.

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

r. History of chronic radiation dermatitis (radiodermatitis).

s. History of scleroderma.

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

u. Current symptomatic plantar wart(s).

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

w. Prior burn injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, temperature regulation, or agility.

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

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

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

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

ab. History of lupus erythematosus.

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

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

ae. History of dermatomyositis.

5.22. BLOOD AND BLOOD FORMING SYSTEM.

a. Current hereditary or acquired anemia.

b. History of coagulation defects.

c. Any history of chronic, or recurrent thrombocytopenia.

d. History of deep venous thrombosis or pulmonary embolism.

e. History of chronic or recurrent agranulocytosis or leukopenia.

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

g. Disorders of the spleen including:

(1) Current splenomegaly.

(2) History of splenectomy.

5.23. SYSTEMIC CONDITIONS.

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

b. Presence of human immunodeficiency virus or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s) is not, in itself, disqualifying with respect to covered personnel (including Military Service Academy cadets and midshipmen, contracted Senior Reserve Officers' Training Corps cadets and midshipmen, and other participants in in-service commissioning programs) seeking to commission while a Service member. Such covered personnel will be evaluated on a case-by-case basis.

c. Tuberculosis.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Infants and Children.

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

(b) Adults.

Systolic BP of less than 90 mmHg or greater than 30 percent decrease from that person's baseline.

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

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

h. History of cold urticaria.

i. History of malignant hyperthermia.

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

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

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

m. History of muscular dystrophies or myopathies.

n. History of amyloidosis.

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

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

q. History of rhabdomyolysis.

r. History of sarcoidosis.

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

5.24. ENDOCRINE AND METABOLIC CONDITIONS.

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

b. Diabetic disorders, including:

(1) History of diabetes mellitus.

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

(3) History of gestational diabetes mellitus.

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

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

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

e. History of diabetes insipidus.

f. History of primary hyperparathyroidism unless surgically corrected.

g. History of hypoparathyroidism.

h. Current goiter.

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

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

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

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

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

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

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

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

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

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

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

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

p. Metabolic bone disease including but not limited to:

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

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

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

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

s. History of gout.

t. History of cross-sex hormone therapy associated with gender transition is disqualifying unless the individual has been stable on such hormones for 18 months or no longer requires such hormones, as certified by a licensed medical provider.

5.25. RHEUMATOLOGIC CONDITIONS.

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

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

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

d. History of rheumatoid arthritis.

e. History of Sjögren's syndrome.

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

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

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

i. History of fibromyalgia or myofascial pain syndrome.

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

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

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

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

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

o. History of scleroderma.

p. History of IgG-4 related disease.

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

5.26. NEUROLOGIC CONDITIONS.

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

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

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

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

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

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

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

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

f. Cluster headaches.

g. History of moderate or severe brain injury if associated with:

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

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

(3) Persistent impairment of cognitive function;

(4) Persistent alteration of personality or behavior;

(5) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging;

(6) Associated abscess or meningitis;

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

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

(9) Any skull fracture.

h. History of mild brain injury if:

(1) The injury occurred within the past month;

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

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

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

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

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

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

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

m. Any atraumatic seizure occurring after the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal sleep-deprived electroencephalogram and normal neurology evaluation while taking no medications for seizure control.

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

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

p. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope, including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.

q. History of muscular dystrophies or myopathies.

5.27. SLEEP DISORDERS.

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

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

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

d. Circadian rhythm disorders requiring treatment or special accommodation.

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

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

5.28. LEARNING, PSYCHIATRIC, AND BEHAVIORAL DISORDERS.

a. Attention Deficit Hyperactivity Disorder, if with:

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

(2) A history of comorbid mental disorders;

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

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

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

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

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

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

c. Autism spectrum disorders.

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

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

f. Depressive disorder if:

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

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

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

(4) Any recurrence; or

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

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

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

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

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

(2) Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to military service; or

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

j. Encopresis after 13th birthday.

k. History of any feeding or eating disorder.

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

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

n. History of self-mutilation.

o. History of obsessive-compulsive disorder.

p. History of post-traumatic stress disorder.

q. History of anxiety disorders if:

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

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

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

(4) Any recurrence.

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

r. History of dissociative disorders.

s. History of somatic symptoms and related disorders.

t. History of gender dysphoria is disqualifying unless, as certified by a licensed mental health provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months.

u. History of paraphilic disorders.

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

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

x. Prior psychiatric hospitalization for any cause.

5.29. TUMORS AND MALIGNANCIES.

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

b. History of malignancy.

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

5.30. MISCELLANEOUS CONDITIONS.

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

b. History of porphyria.

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

d. History of angioedema, including hereditary angioedema.

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

f. History of pulmonary or systemic embolism.

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

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

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

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

GLOSSARY

G.1. ACRONYMS.

ACRONYM	MEANING
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AV	Atrioventricular
BP	blood pressure
cm	Centimeters
dB	decibel
DoDI	DoD instruction
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dL	milligrams per deciliter
mm	millimeters
mmHg	millimeters of mercury
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

G.2. DEFINITIONS.

Unless otherwise noted, these terms and their definitions are for the purpose of this volume.

TERM	DEFINITION
504 Plan	The 504 Plan is a plan developed to ensure that a child who has a disability identified under Section 504 of the Rehabilitation Act of 1973 as amended and codified at Section 701 of Title 29, U.S.C. and is attending an elementary or secondary educational institution, receives accommodations that will ensure their academic success and access to the learning environment.
accession	An enlistment that increases the incremental strength of the Regular or Reserve Components of the Military Services. Personnel enlisted under the Delayed Entry Program are not involved in this category.
covered personnel	Individuals who have been identified as HIV positive, are asymptomatic, and who have a clinically confirmed undetectable viral load.

TERM	DEFINITION
cross-sex hormone therapy	The use of feminizing hormones in an individual with a biological sex of male or the use of masculinizing hormones in an individual with a biological sex of female.
existed prior to Service	A term used to signify there is clear and unmistakable evidence that the disease or injury, or the underlying condition producing the disease or injury, existed prior to the individual's entry into military service.
induction	Transition from civilian to military status for a period of definite military obligation under Chapter 49 of Title 50, U.S.C. also known as the "Military Selective Service Act."
licensed mental health provider	A psychiatrist, clinical psychologist, clinical social worker with a master's degree or doctorate in clinical social work, or psychiatric nurse practitioner.
medical waiver	A formal request to consider the suitability for service of an applicant who, because of current or past medical conditions, does not meet medical standards. Upon the completion of a thorough review, the applicant may be considered for a waiver. The applicant must have displayed sufficient mitigating circumstances/provided medical documentation that clearly justify waiver consideration. The Secretaries of the Military Departments may delegate the final approval authority for all waivers.
medpers	Includes leaders from the medical and personnel communities to develop, discuss, and make decisions about common medical issues that require resolution. The primary focus is the nexus of medical and personnel systems that impact the total force to include those seeking entry into the armed forces and those who must depart prior to completion of an enlistment or career.
mild head injury	Unconsciousness of less than 30 minutes post-injury, or amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.
military department	Defined in the DoD Dictionary of Military and Associated Terms.
moderate brain injury	Unconsciousness of more than 30 minutes but less than 24 hours, or amnesia, or disorientation of person, place or time, alone or in combination, lasting more than 24 hours but less than 7 days after the injury.

TERM	DEFINITION
national heart, lung, and blood institute	An agency within the National Institutes of Health that provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.
self-identified gender	The gender with which an individual identifies.
severe brain injuries	Unconsciousness of 24 hours or more post injury, or amnesia or disorientation of person, place or time longer than 7 days after the injury.

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

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

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

Exhibit 2B

DoDI 6130.03, Vol. 1

(Nov. 16, 2022)

DoD INSTRUCTION 6130.03, VOLUME 1

MEDICAL STANDARDS FOR MILITARY SERVICE: APPOINTMENT, ENLISTMENT, OR INDUCTION

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective: **Change 4 Effective:**	May 6, 2018 November 16, 2022
Releasability:	Cleared for public release. Available on the Directives Division Website at https://www.esd.whs.mil/DD/.
Reissues and Cancels:	DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
Approved by:	Robert L. Wilkie, Under Secretary of Defense for Personnel and Readiness
Change 4 Approved by:	Gilbert R. Cisneros, Jr., Under Secretary of Defense for Personnel and Readiness

Purpose: This instruction is composed of two volumes, each containing its own purpose. In accordance with the authority in DoD Directive 5124.02:

- This instruction establishes policy, assigns responsibilities, and prescribes procedures for medical standards for appointment, enlistment, or induction into the Military Services.
- This volume establishes physical and medical standards for appointment, enlistment, or induction into the Military Services.

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This volume 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 Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

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

(3) The United States Merchant Marine Academy in accordance with Section 310.56 of Title 46, Code of Federal Regulations requiring the candidate to meet the physical requirements prescribed by the Department of the Navy for appointment as a midshipman in the United States Navy Reserve.

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

1.2. POLICY.

It is DoD policy to:

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

b. Use common medical standards for appointment, enlistment, or induction of personnel into the Military Services.

c. Eliminate inconsistencies and inequities in the DoD Components, in accordance with DoD Instruction (DoDI) 1350.02, based on race, sex, gender identity, sexual orientation, or location of examination when applying these standards. The DoD Components will consider disqualification for pregnancy as temporary.

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

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

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

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

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

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

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

1.3. INFORMATION COLLECTIONS.

DD Form 2807-2, "Accessions Medical History Report"; DD Form 2808, "Report of Medical Examination"; or equivalent electronic templates and the supplemental health documents referred to in Paragraph 2.4.d.(2) of this volume have been assigned Office of Management and Budget control number 0704-0413 in accordance with the procedures in Volume 2 of DoD Manual 8910.01. The expiration date of this information collection is listed on the DoD Information Collections System at https://reginfo.gov/public.

1.4. SUMMARY OF CHANGE 4.

The changes to this volume update medical standards and procedures for applicants.

SECTION 2: RESPONSIBILITIES

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

The USD(P&R):

a. Ensures that the standards in Sections 5 and 6 are implemented throughout the DoD Components.

b. Eliminates inconsistencies and inequities, in accordance with DoDI 1350.02, based on race, sex, gender identity, sexual orientation, or location of examination in DoD Component application of these standards.

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

d. Through the Assistant Secretary of Defense for Manpower and Reserve Affairs, the Deputy Assistant Secretary of Defense for Military Personnel Policy provides guidance to the United States Military Entrance Processing Command (USMEPCOM) to implement the standards in Sections 5 and 6 for all Services.

2.2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS.

Under the authority, direction, and control of the USD(P&R), the Assistant Secretary of Defense for Health Affairs reviews, approves, and issues clarifying guidance regarding the standards in Sections 5 and 6.

2.3. DIRECTOR, DEFENSE HEALTH AGENCY.

Under the authority, direction, and control of the USD(P&R), through the Assistant Secretary of Defense for Health Affairs, the Director, Defense Health Agency:

a. In accordance with DoD Directive 5124.02, provides guidance to the DoD Medical Examination Review Board (DoDMERB) to implement the standards in Sections 5 and 6.

b. Coordinates with, and supports, the Secretary of the Navy with processing applicants seeking entry into the Military Services from Guam and the surrounding area.

2.4. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD.

The Secretaries of the Military Departments and the Commandant, United States Coast Guard:

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

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

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

d. Ensure that medical information for "Existed Prior to Service" discharges is provided to the USMEPCOM by Service training centers conducting basic military training. Medical information includes:

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

(2) Copies of DD Forms 2807-2; 2807-1, "Report of Medical History"; and 2808 or equivalent electronic templates, including supplemental behavioral health screening documents.

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

e. Eliminate inconsistencies and inequities, in accordance with DoDI 1350.02, based on race, sex, gender identity, sexual orientation, or examination location in the application of these standards by the DoD Components and ensure all personally identifiable information is handled in accordance with DoDI 5400.11 and DoD 5400.11-R.

2.5. SECRETARY OF THE NAVY.

In addition to the responsibilities in Paragraph 2.4., the Secretary of the Navy directs the medical processing for applicants seeking entry into the Military Services from Guam and the surrounding area while applying and uniformly implementing the standards contained within this volume.

SECTION 3: MEDPERS

3.1. ORGANIZATION.

The MEDPERS convenes at least twice a year under the joint guidance of the Deputy Assistant Secretary of Defense for Military Personnel Policy (DASD(MPP)) and the Deputy Assistant Secretary of Defense for Health Services Policy and Oversight (DASD(HSP&O)) and in accordance with the MEDPERS charter.

3.2. AGENDA.

The MEDPERS:

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

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

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

SECTION 4: ARMSWG

4.1. PURPOSE.

The ARMSWG—a chartered working group under the MEDPERS—convenes at least quarterly, under the joint guidance of the DASD(HSP&O) and the DASD(MPP), to bring together representatives from the DoD medical and personnel community for the development, discussion, and recommendation of issues pertaining to military medical standards for accession, enlistment and induction of personnel into military service, and retention in military service.

4.2. OVERALL GOALS.

The ARMSWG:

a. Provides guidance to Medical Standards Analytics and Research on accession- and retention-related operational analysis and research performed to support life-cycle medical standards.

b. Provides a forum for discussing interrelated personnel and medical issues related to accession and retention, such as:

(1) The operational capability of personnel to ensure the best physical and medical outcomes of the military force.

(2) Cost considerations to maintain a force of healthy Service members.

(3) Medical conditions that may interfere with the capability of personnel completing training and maintaining worldwide deployability.

c. Reviews and develops proposed updates to this volume.

d. Reviews, develops and submits proposed updates to Volume 2 of this issuance to USD(P&R).

e. Receives and responds to taskings from MEDPERS and makes recommendations to MEDPERS regarding accession and retention medical issues as appropriate.

f. Maintains records and minutes of ARMSWG meetings.

4.3. CO-CHAIRS.

The DASD(HSP&O) and the DASD(MPP) will each select one representative to co-chair the ARMSWG. The ARMSWG co-chairs will:

a. Draft the ARMSWG charter for MEDPERS approval.

b. Record and retain meeting minutes and other committee records.

c. Schedule meetings as required.

4.4. MEMBERSHIP.

The ARMSWG membership will include medical and personnel representatives from:

a. Each Military Service.

b. The Joint Staff.

c. Other organizations as required in accordance with the ARMSWG charter.

SECTION 5: MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION

5.1. APPLICABILITY.

The medical standards in this volume apply to:

a. Applicants for appointment as commissioned or warrant officers or enlistment in any Military Service and Component, to include federally recognized units or organizations of the National Guard.

(1) For medical conditions or defects that predate the current enlistment or appointment and were not aggravated in the line of duty, these standards apply to enlistees during the first 6 months of the current period of active duty or during the applicant's initial period of active duty for training until their return to the Reserve Components.

(2) For medical conditions or defects that did not predate the current enlistment or appointment but occurred prior to the applicant shipping for the initial period of active duty for training.

(3) Applicants for re-accession in any Military Service and Component, including federally recognized units or organizations of the National Guard after a period of more than 12 months have elapsed since the date on their DD Form 214, "Certificate of Uniformed Service," or separation orders, as applicable. These applicants no longer have a status in any component of the military.

b. The medical standards in this volume do not apply to:

(1) For medical conditions or defects that predate the current enlistment and were aggravated in the line of duty refer to Volume 2.

(2) For medical conditions or defects that did not predate the current enlistment or appointment, but that occurred during the initial period of active duty refer to Volume 2.

(3) For Servicemembers currently serving in the Individual Ready Reserves refer to Volume 2.

5.2. PROCEDURES.

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

(1) Fully disclose all medical history.

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

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

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

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

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

(5) Acknowledge that any cadet or midshipman, whether contracted or noncontracted, who has a change in medical status that is related to a standard in this regulation, understands that the change may disqualify them and that they will require an evaluation or physical before determining accession qualifications.

b. The USMEPCOM and DoDMERB will:

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

(2) Use coding to document personnel actions in order to collect information to enable research, analyses, and support for evidence-based medical standards. Medical disqualifications will be coded in a manner that indicates which medical standard described in Section 6 is disqualifying.

c. The DoD Components:

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

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

SECTION 6: DISQUALIFYING CONDITIONS

6.1. MEDICAL STANDARDS.

a. Unless otherwise stipulated, the conditions listed in this section are those that do not meet the standard by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment, or induction into the Military Services are classified into general systems in Paragraphs 6.2. through 6.30.

b. Unless otherwise stipulated, the standards in this section apply to an applicant's biological sex or the presence of male or female sex organs or tissue.

6.2. HEAD.

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

b. Loss, or absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving any residual defect in excess of 1 square inch (6.45 square centimeters), or the size of a U.S. quarter coin.

6.3. EYES.

a. Lids.

(1) Current symptomatic blepharitis.

(2) Current blepharospasm.

(3) Current dacryocystitis, acute or chronic.

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

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

b. Conjunctiva.

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

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

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

c. Cornea.

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

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

(3) Corneal refractive surgery performed with an excimer or femtosecond laser, including, but not limited to, photorefractive keratectomy, laser epithelial keratomileusis, laser-assisted in situ keratomileusis, and small incision lenticule extraction, if any of the following conditions are met:

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

(b) Pre-surgical astigmatism exceeded 3.00 diopters.

(c) Within 180 days of accession medical examination.

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

(e) Post-surgical refraction in each eye is not stable.

1. For refractive surgery procedures within the previous 36 months, stability is demonstrated by at least two separate post-operative refractions performed at least 1 month apart that demonstrate no more than +/- 0.50 diopters difference in sphere or no more than +/- 0.50 diopters in cylinder.

2. For refractive surgery procedures more than 36 months ago, stability is demonstrated by at least two separate post-operative refractions that demonstrate no more than +/- 1.00 diopters difference in sphere or no more than +/- 1.00 diopters in cylinder.

(4) Current or recurrent keratitis.

(5) History of herpes simplex virus keratitis.

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

(7) Any history of uveitis or iridocyclitis.

d. Retina.

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

e. Optic Nerve.

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

(2) Any optic nerve anomaly.

f. Lens.

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

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

g. Ocular Mobility and Motility.

(1) Current or recurrent diplopia.

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

(3) Strabismus, if any of the conditions in Paragraphs 6.3.g.(a)-(d) apply:

(a) Esotropia more than 15 prism diopters;

(b) Exotropia more than 10 prism diopters;

(c) Hypertropia more than 5 prism diopters; or

(d) Strabismus resulting in posturing (head tilt or turn), diplopia, or correctable vision that does not meet the applicable standards for enlistment or commission.

(4) History of restrictive ophthalmopathies.

h. Miscellaneous Defects and Diseases.

(1) History of abnormal visual fields.

(2) Absence of an eye.

(3) History of disorders of globe.

(4) Current unilateral or bilateral exophthalmoses.

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

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

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

(8) Current night blindness.

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

(10) History of ocular tumors.

(11) History of any abnormality of the eye or adnexa, not specified in Paragraphs 6.3.h.(1)-(10), which threatens vision or visual function.

6.4. VISION.

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

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

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

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

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

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

6.5. EARS.

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

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

c. Recurrent or persistent vertigo in the previous 12 months.

d. History of any surgically implanted hearing device.

e. History of cholesteatoma.

f. History of any inner or middle ear surgery.

g. Current perforation of the tympanic membrane or history of surgery to correct perforation during the preceding 6 months.

h. Chronic Eustachian tube dysfunction as evidenced by any of the conditions in Paragraphs 6.6.h.(1)–(3) in the previous 24 months:

(1) More than one episode of acute otitis media, serous otitis media, or persistent middle ear effusion;

(2) Pressure equalization tubes; or

(3) Any atraumatic tympanic membrane rupture.

6.6. HEARING.

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

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

(1) Twenty-five decibels (dB) averaged at 500, 1000, and 2000 cycles per second;

(2) Thirty dB at 500, 1000, or 2000 cycles per second;

(3) Thirty-five dB at 3000 cycles per second;

(4) Forty-five dB at 4000 cycles per second; or

(5) No standard for 6000 cycles per second.

c. Unexplained asymmetric hearing loss as defined by a difference of 30 or more dB between the left and right ears at any one or more frequencies between 500 hertz, 1000 hertz, or 2000 hertz.

d. History of using hearing aids.

6.7. NOSE, SINUSES, MOUTH, AND LARYNX.

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

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

c. Symptomatic vocal cord dysfunction, including, but not limited to:

(1) Vocal cord paralysis.

(2) Paradoxical vocal cord movement.

(3) Spasmodic dysphonia.

(4) Non-benign polyps.

(5) Chronic hoarseness.

(6) Chronic laryngitis (lasting longer than 21 days).

(7) History of vocal cord dysfunction with respiratory symptoms or exercise intolerance.

d. Current olfactory deficit.

e. Greater than one episode of epistaxis requiring medical intervention (urgent care or emergency department treatment or procedure) in the past 24 months.

f. Current chronic sinusitis, current nasal polyp or polypoid mass(es) or history of sinus surgery within the last 24 months, excluding antralchoanal polyp or sinus mucosal retention cyst.

g. Current symptomatic perforation of nasal septum.

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

6.8. DENTAL.

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

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

c. Current severe malocclusion, which interferes with normal chewing or requires immediate and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement.

d. Eight or more teeth with visually apparent decay, cavities, or caries.

e. Large edentulous areas of greater than four contiguous missing teeth, unless restored by a well-fitting prosthesis (e.g., fixed bridge, implants, or removable dentures) that allows for adequate chewing and processing of a normal diet.

f. Ongoing endodontic (root canal) treatment, unless the applicant is entering the Delayed Entry Program and a civilian or military dentist or endodontist provides documentation that active endodontic treatment will be completed before the anticipated date of being sworn to active duty.

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

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

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

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

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

h. The presence of wisdom teeth (third molars), if currently symptomatic.

6.9. NECK.

a. Current presence of a cervical rib, if it has caused symptoms, including, but not limited to, thoracic outlet syndrome, subclavian vein thrombosis, or other symptoms of nerve or vascular compression.

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

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

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

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

b. Current abscess of the lung or mediastinum.

c. Infectious pneumonia within the previous 3 months.

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

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

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

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

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

g. Bronchiectasis (after the 1st birthday).

h. Bronchopleural fistula, unless resolved with no sequelae.

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

j. History of empyema unless resolved with no sequelae.

k. Interstitial lung disease including pulmonary fibrosis.

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

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

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

o. History of spontaneous pneumothorax.

p. Pneumothorax due to trauma or surgery occurring within the previous 12 months.

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

r. Tuberculosis:

(1) History of active pulmonary or extra-pulmonary tuberculosis in the previous 24 months or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment, or

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

s. History of pulmonary or systemic embolus.

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

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

v. History of pulmonary hypertension or right ventricular systolic pressure greater than 30 mmHg or pulmonary artery systolic pressure greater than or equal to 36 mmHg on the most recent echocardiogram.

6.11. HEART.

a. History of valvular repair or replacement.

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

(1) Moderate or severe pulmonic regurgitation.

(2) Moderate or severe tricuspid regurgitation.

(3) Moderate or severe mitral regurgitation.

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

(5) Mitral valve prolapse associated with:

(a) Mild or greater mitral regurgitation.

(b) Cardiopulmonary symptoms.

(c) Medical therapy specifically for this condition.

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

d. All valvular stenosis.

e. History of atherosclerotic coronary artery disease.

f. The presence of an implantable pacemaker or defibrillator.

g. History of supraventricular tachycardia if:

(1) History of atrial fibrillation or flutter.

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

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

i. Abnormal findings on the most recent electrocardiogram (ECG), with the exception of the findings in Paragraphs 6.11.i.(1)-(10) in an asymptomatic applicant with a normal clinical examination:

(1) Incomplete right bundle branch block.

(2) Early repolarization.

(3) Sinus bradycardia with a rate between 40 and 59 beats per minute.

(4) Ectopic atrial or junctional rhythm.

(5) Sinus arrhythmia (heart rate variation with respiration).

(6) First-degree AV block.

(7) Mobitz Type I (Wenckebach) second-degree AV block.

(8) Left axis deviation defined as QRS axis -30 degrees to -90 degrees.

(9) Right axis deviation defined as QRS axis more than 120 degrees.

(10) Single preventricular contraction PVC on a 10-second tracing.

j. The following abnormal electrocardiograph patterns:

(1) Long QT (QTc of more than 470 milliseconds in males or more than 480 milliseconds in females);

(2) Brugada Type I pattern.; or

(3) Ventricular pre-excitation pattern that does not meet the qualification criteria in Paragraph 6.11.g.

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

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

m. History of myocardial infarction or congestive heart failure.

n. History of cardiomyopathy or hypertrophy.

o. Any personal history of hypertrophic cardiomyopathy or a family history hypertrophic cardiomyopathy, unless the applicant is asymptomatic with a normal echocardiogram performed within the previous 12 months.

p. History of myocarditis or pericarditis unless the individual is free of all cardiac symptoms, does not require medical therapy, and has a normal electrocardiogram and a normal echocardiogram for at least 12 months after the event.

q. History of recurrent myocarditis or pericarditis.

r. Tachycardia as indicated by a resting heart rate of more than 100 beats per minute present on three or more separate measurements.

s. History of congenital anomalies of the heart and great vessels other than the following conditions. Excepted conditions require the applicant to be asymptomatic with an otherwise normal current echocardiogram within the previous 12 months and no residual symptoms (e.g., pulmonary hypertension, myocardial dysfunction, or arrythmia).

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

(2) Ligated or occluded patent ductus arteriosus.

(3) Corrected atrial septal defect without residua.

(4) Patent foramen ovale.

(5) Corrected ventricular septal defect without residua.

t. History of recurrent syncope or presyncope, including black out, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture) unless it has not recurred during the previous 24 months while off all medication for treatment of this condition.

u. Unexplained cardiopulmonary symptoms (including, but not limited to, syncope, presyncope, chest pain, palpitations, and dyspnea on exertion) in the previous 12 months.

v. History of Postural Orthostatic Tachycardia Syndrome (POTS) or syndrome of inappropriate sinus tachycardia (IST).

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

6.12. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

a. Esophageal Disease.

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

(a) Stricture.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagus.

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

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

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

(4) History of eosinophilic esophagitis.

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

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

b. Stomach and Duodenum.

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

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

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

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

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

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

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

(6) History of gastric varices.

c. Small and Large Intestine.

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

(2) Current infectious colitis.

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

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

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

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

(7) History of diarrhea of greater than 6 weeks' duration, regardless of cause, persisting or symptomatic in the previous 24 months.

(8) History of gastrointestinal bleeding, including positive occult blood, if:

(a) The cause is known but has not been corrected; or

(b) The cause is unknown and bleeding has occurred within the previous 12 months.

(9) History of irritable bowel syndrome that has been symptomatic or medically managed within the previous 24 months.

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

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

d. Hepatic-Biliary Tract.

(1) History of chronic Hepatitis B unless successfully treated and the cure is documented. A documented cure for Hepatitis B is viral clearance as evidenced by Hepatitis B serology:

(a) Surface antigen negative.

(b) Surface antibody positive.

(c) Core antibody positive.

(2) History of chronic Hepatitis C, unless successfully treated and with documentation of a cure as evidenced by a viral load of "0" or "undetectable" measured at least 12 weeks after completion of a full course of therapy.

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

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

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

(6) History of sphincter of Oddi dysfunction.

(7) History of choledochal cyst.

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

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

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

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

e. Pancreas.

History of:

(1) Pancreatic insufficiency.

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

(3) Chronic pancreatitis.

(4) Pancreatic cyst or pseudocyst.

(5) Pancreatic surgery.

f. Anorectal.

(1) Current anal fissure or anal fistula.

(2) History of rectal prolapse or stricture within the previous 24 months.

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

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

g. Abdominal Wall.

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

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

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

6.13. FEMALE GENITAL SYSTEM.

a. Abnormal uterine bleeding associated with any of the conditions in Paragraph 6.13.a.(1)-(4):

(1) Heavy menstrual bleeding within the previous 6 months defined as periods:

(a) Heavy enough to soak more than one pad per hour on more than two cycles within the previous 6 months;

(b) Lasting longer than 8 days on more than one cycle within the preceding 6 months; or

(c) Associated with anemia.

(2) Irregular menses more than twice within the previous 6 months defined as periods that were fewer than 21 days apart or associated with anemia.

(3) Oligomenorrhea of fewer than four menstrual cycles within the previous 6 months, unless a result of intentional menstrual suppression via external hormone regulation, an implant, or an intrauterine device.

(4) More than 1 day of school or work missed in the previous 6 months due to symptoms associated with menstrual cycles.

b. Primary amenorrhea.

c. Current unexplained secondary amenorrhea.

d. Dysmenorrhea resulting in missing more than 1 day of work or school within the previous 6 months.

e. History of symptomatic endometriosis.

f. Any undiagnosed or untreated disorder of sex development.

g. History of urogenital reconstruction or surgery (including, but not limited to, gender-affirming surgery), if:

(1) A period of 18 months has not elapsed since the date of the most recent surgery;

(2) Associated with genitourinary dysfunction or recurrent urinary tract infection;

(3) Associated with functional limitations of activities of daily living or a physically active lifestyle; or

(4) Additional surgery is anticipated.

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

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

j. Current pelvic inflammatory disease.

k. History of chronic pelvic pain (6 months or longer) within the previous 24 months.

l. Pregnancy through 6 months postpartum.

m. Current uterine enlargement.

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

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

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

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

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

o. Abnormal cervical, vaginal, or vulvar cytology if:

(1) The most recent exams shows cervical intraepithelial neoplasia II or higher grade cytology, independent of human papillomavirus status;

(2) The applicant's treating healthcare provider recommends an ongoing surveillance or treatment schedule more frequent than every 6 months; or

(3) There has been a finding of ASCUS-H, atypical squamous cells of undetermined significance, human papillomavirus positive, or low-grade squamous intraepithelial lesion that has not received follow-up testing with a repeat pap smear, colposcopy, or co-testing to confirm cervical intraepithelial neoplasia grade I or lower grade.

p. Any history of vaginal, vulvar, or cervical intraepithelial neoplasia grade 3 or higher within the previous 36 months.

q. History of abnormal endometrial pathology excluding benign endometrial polyp.

6.14. MALE GENITAL SYSTEM.

a. Current undescended testicle, congenital absence of one or both testicles that has not been verified by surgical exploration, or unexplained absence of both testicles.

b. History of epispadias or hypospadias when accompanied by history of urinary tract infection, urethral stricture, urinary incontinence, symptomatic chordee, or genitourinary dysfunction unless currently asymptomatic and more than 18 months.

c. Current enlargement or mass of testicle, epididymis, or spermatic cord, in addition to those described elsewhere in Paragraph 6.14.

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

e. Current varicocele, unless it is:

(1) On the left side only.

(2) Asymptomatic and smaller than the testes.

(3) Reducible.

(4) Without associated testicular atrophy.

f. Current or history of recurrent orchitis or epididymitis.

g. History of penis amputation that has not been definitively surgically treated to establish a functional urinary tract.

h. History of Peyronie's disease.

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

(1) Current lesions are present;

(2) Use of chronic suppressive therapy is needed;

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

(4) Any outbreak in the previous 12 months interfered with normal activities; or

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

j. History of urethral condyloma acuminatum.

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

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

m. Any undiagnosed or untreated disorder of sex development.

n. History of urogenital reconstruction or surgery (including, but not limited to, gender-affirming surgery), if:

(1) A period of 18 months has not elapsed since the date of the most recent surgery;

(2) Associated with genitourinary dysfunction or recurrent urinary tract infection;

(3) Associated with functional limitations of activities of daily living or a physically active lifestyle; or

(4) Additional surgery is anticipated.

6.15. URINARY SYSTEM.

a. History of interstitial cystitis or painful bladder syndrome.

b. Lower urinary tract infection (cystitis):

(1) For males, any cystitis not related to an indwelling catheter or genitourinary surgery.

(2) For females:

(a) Current cystitis; or

(b) Recurrent cystitis, not related to an indwelling catheter or genitourinary surgery, defined as:

1. Two episodes of acute bacterial cystitis and associated symptoms within the previous 6 months;

2. Three episodes within the previous 12 months;

3. Requiring daily suppressive antibiotics; or

4. Non-responsive to antibiotics for 10 days.

c. Current urethritis.

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

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

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

(3) Enuresis.

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

(5) Urinary retention.

(6) Dysuria.

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

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

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

(1) Gross hematuria.

(2) Persistent microscopic hematuria (3 or more red blood cells per high-powered field urinalyses).

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

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

i. Absence of one kidney, congenital or acquired.

j. Asymmetry in size or function of kidneys, including, but not limited to, duplex kidney.

k. History of renal transplant.

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

m. History of polycystic kidney.

n. History of horseshoe kidney.

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

p. History of acute nephritis.

q. History of chronic kidney disease of any type as evidenced by:

(1) Estimated glomerular filtration rate of less than 60 milliliters per minute per 1.73 square meter of body surface area for a period of 3 months or longer;

(2) Abnormal renal imaging;

(3) Cellular casts or active urine sediment; or

(4) Abnormal renal biopsy.

r. History of acute kidney injury requiring dialysis.

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

t. Urolithiasis if any of the following apply:

(1) Current stone of 3 mm or greater.

(2) Current multiple stones of any size.

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

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

(5) History of urolithiasis requiring a procedure.

6.16. SPINE AND SACROILIAC JOINT CONDITIONS.

a. Ankylosing spondylitis or other inflammatory spondylopathies.

b. History of any condition, in the previous 24 months, or any recurrence, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:

(1) It presented the individual from successfully following a physically active avocation in civilian life, or was associated with local or radicular pain, muscular spasms, postural deformities, or limitation in motion;

(2) It required external support;

(3) It required frequent treatment or limitation of activities of daily living or a physically active lifestyle; or

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

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

(6) It involved surgery to the spine or spinal cord, other than a single-level lumbar or thoracic diskectomy, meeting the criteria in Paragraph 6.16.i.

(7) It required interventional procedures, including, but not limited to, spinal injections, nerve blocks, or radio ablation procedures.

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

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

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

(3) It is symptomatic within the previous 24 months; or

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

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

e. Current dislocation of the vertebra.

f. History of vertebral fractures including:

(1) Cervical spine fracture.

(2) Fracture(s) of elements of the posterior arch (i.e., pedicle, lamina, pars intraarticularis).

(3) Fracture of lumbar or thoracic vertebral body that exceeds 25 percent of the height of a single vertebra or that has occurred within the previous 12 months or is symptomatic.

(4) Fractures of the transverse or spinous process if currently symptomatic.

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

h. History of lumbar disc pathology, including, but not limited to, bulges, herniations, protrusions, and extrusions associated with symptoms, treatment, or limitations of activities of daily living or a physically active lifestyle, in the previous 24 months or any history of recurrent symptoms.

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

j. Spinal dysraphisms other than spina bifida occulta.

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

6.17. UPPER EXTREMITY CONDITIONS.

a. Limitation of Motion.

Current active joint ranges of motion less than:

(1) Shoulder.

(a) Forward elevation to 130 degrees.

(b) One hundred and thirty degrees abduction.

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

(d) Cross body reaching 115 degrees adduction.

(2) Elbow.

(a) Flexion to 130 degrees.

(b) Extension to 30 degrees.

(3) Forearm.

(a) Pronation to 60 degrees.

(b) Supination to 60 degrees.

(4) Wrist.

(a) Forty degrees of flexion;

(b) Forty degrees of extension; or

(c) Forty degrees of combined radial-ulnar deviation.

(5) Hand, Fingers, and Thumb.

Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Fingers.

(1) Absence of any bony portion of the fingers or thumb.

(2) Absence of hand or any portion thereof.

(3) Current polydactyly or syndactyly.

(4) Current intrinsic hand muscle paralysis, weakness (4 or less on a scale of 5 using a manual muscle test), or atrophy of the hand or thenar, including, but not limited to, those caused by nerve paralysis, nerve injury, or nerve entrapment (carpal, radial and cubital tunnel syndromes, and brachial plexus).

c. Residual Weakness and Pain.

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

6.18. LOWER EXTREMITY CONDITIONS.

a. General.

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

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

b. Limitation of Motion.

Current active joint ranges of motion less than:

(1) Hip.

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

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

(d) Abduction to 45 degrees.

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

(2) Knee.

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle.

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle.

(1) Current absence of a foot or any portion thereof, other than absence of a single lesser toe that is asymptomatic and does not impair function of the foot.

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

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

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

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

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

(7) Current or recurrent plantar fasciitis.

(8) Symptomatic neuroma.

d. Leg, Knee, Thigh, and Hip.

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

(2) Instability of the knee, as evidenced by:

(a) Three or more surgeries in the same knee joint.

(b) History of posterior cruciate ligament tear or partial anterior cruciate ligament tear within the previous 12 months or that is not fully rehabilitated.

(3) Complete anterior cruciate ligament tear that has not been surgically corrected.

(4) History of surgical reconstruction of knee ligaments within the previous12 months, or which is symptomatic or unstable or shows signs of thigh or calf atrophy.

(5) Recurrent anterior cruciate ligament reconstruction.

(6) Current medial or lateral meniscal injury with symptoms or limitation of activities of daily living or a physically active lifestyle.

(7) Surgical meniscal repair, within the previous 6 months or with residual symptoms or limitation of activities of daily living or a physically active lifestyle.

(8) Surgical partial meniscectomy within the previous 3 months or with residual symptoms or limitation of activities of daily living or a physically active lifestyle.

(9) Meniscal transplant.

(10) Symptomatic medial and lateral collateral ligament instability or injury.

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

(12) History of hip dislocation.

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

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

(15) Recurrent periostitis, shin splints, or tibial stress syndrome within the previous 12 months.

6.19. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES.

a. History of clinically diagnosed anterior knee pain including, but not limited to:

(1) Patellofemoral syndrome.

(2) Patellofemoral pain syndrome.

(3) Chondromalacia patella that was symptomatic or required treatment or limitations of activities of daily living or a physically active lifestyle in the previous 12 months.

(4) Any history of recurrent anterior knee pain syndrome.

b. History of any dislocation, subluxation, or instability of the hip, knee, ankle, subtalar joint, foot, shoulder, wrist, elbow except for "nursemaid's elbow" or dislocated finger.

c. Acromioclavicular separation within the previous 12 months or if symptomatic.

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

e. Fractures, if:

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

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

f. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities except for bone anchor and hardware as allowed in accordance with Paragraph 6.19.f.(2).

g. History of contusion of bone or joint if:

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

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

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

(4) The contusion requires frequent or prolonged treatment.

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

i. History of hip arthroscopy or femoral acetabular impingement.

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

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

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

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

n. History of osteomyelitis within the previous 12 months, or history of recurrent osteomyelitis.

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

p. Surgically or radiographically demonstrated chondromalacia of Grade II or higher.

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

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

s. History of osteonecrosis of any bone.

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

u. Stress reaction in a weight bearing bone within the previous 6 months.

6.20. VASCULAR SYSTEM.

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

b. Current or medically-managed hypertension.

c. Elevated systolic blood pressure of greater than 140 mm of mercury (mmHg) or diastolic pressure greater than 90 mmHg confirmed by a manual blood pressure cuff averaged over two or more properly measured, seated blood pressure readings on separate days within a 5-day period (an isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 separate days within a 5-day period).

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

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

f. History of deep venous thrombosis or pulmonary embolism.

g. History of operation or endovascular procedure on the arterial or venous systems, including, but not limited to, vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement.

h. History of Marfan's Syndrome, Loeys-Dietz, or Ehlers Danlos IV.

i. Dilatation of the aorta on the most recent ECG, CT, or MRI, including aortic root and ascending thoracic aorta.

j. Coarctation of the aorta regardless of treatment by surgery, balloon, or stent.

6.21. SKIN AND SOFT TISSUE CONDITIONS.

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

b. Severe nodulocystic acne, on or off antibiotics.

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

d. History of atopic dermatitis or eczema requiring treatment other than over-the-counter hydrocortisone or moisturizer therapy in the previous 36 months or with active lesions or residual hyperpigmented or hypopigmented areas at the time of the entrance examination.

e. History of recurrent or chronic non-specific dermatitis within the previous 24 months, including contact (irritant or allergic) or dyshidrotic dermatitis requiring treatment other than over-the-counter medication.

f. Cysts, if:

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

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

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

h. Current or chronic lymphedema.

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

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

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

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

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

n. History of photosensitivity, including, but not limited to, any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus, porphyria, and xeroderma pigmentosa.

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

p. History of chronic radiation dermatitis (radiodermatitis).

q. History of scleroderma.

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

s. Current symptomatic plantar wart(s).

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

u. Prior burn injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, temperature regulation, or agility.

v. Current localized fungal infections, if they can be reasonably expected to interfere with properly wearing military equipment or performing military duties. For systemic fungal infections, refer to Paragraph 6.23.s.

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

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

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

z. History of lupus erythematosus.

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

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

ac. History of dermatomyositis.

6.22. BLOOD AND BLOOD FORMING SYSTEM.

a. Acquired anemia (hemoglobin less than 13.5 grams per deciliter (g/dl) for males or less than 12 g/dl for females) that has not been corrected to normal values as evidenced by a normal hemoglobin within 6 months or that requires ongoing maintenance with agents other than oral supplementation, diet, or menstruation control.

b. Hereditary hemoglobin disorders, if any of the following apply (Sickle cell trait with hemoglobin S fraction of less than 45 percent; alpha thalassemia trait and beta thalassemia trait in the absence of anemia are normal variants and are not considered hemoglobin disorders. Hereditary hemoglobin disorders are disqualifying, if any of the following apply):

(1) Sickle cell disease (e.g., hemoglobin SS, hemoglobin SC, and hemoglobin S/beta thal);

(2) Associated with anemia (hemoglobin less than 13.5 g/dl for males or less than 12 g/dl for females);

(3) Sickle cell trait with a hemoglobin S fraction of 45 percent or higher; or

(4) History of exercise collapse in an individual with sickle cell trait.

c. History of coagulation defects.

d. Any history of chronic, or recurrent thrombocytopenia.

e. History of deep venous thrombosis or pulmonary embolism.

f. History of chronic or recurrent agranulocytosis or leukopenia.

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

h. Disorders of the spleen including:

(1) Current splenomegaly.

(2) History of splenectomy.

6.23. SYSTEMIC CONDITIONS.

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

b. Presence of human immunodeficiency virus (HIV) or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s) is not, in itself, disqualifying with respect to covered personnel (including Military Service Academy cadets and midshipmen, contracted SROTC cadets and midshipmen, and other participants in in-service commissioning programs) seeking to commission while a Service member). Such covered personnel will be evaluated on a case-by-case basis.

c. Tuberculosis

(1) History of active pulmonary or extra pulmonary tuberculosis in the previous 24 months or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment.

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

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

e. History of anaphylaxis other than anaphylaxis to a single medication or medication class.

f. History of systemic allergic reaction to biting or stinging insects, unless it was limited to a large local reaction or unless there is documentation of 3 years of maintenance venom immunotherapy.

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

h. History of cold- or exercise-induced urticaria.

i. History of malignant hyperthermia.

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

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

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

m. History of muscular dystrophies or myopathies.

n. History of amyloidosis.

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

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

q. History of rhabdomyolysis.

r. History of sarcoidosis.

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

t. History of angioedema, other than angioedema in response to a single medication or medication class.

6.24. ENDOCRINE AND METABOLIC CONDITIONS.

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

b. Diabetic disorders, including:

(1) History of diabetes mellitus.

(2) History of unresolved pre-diabetes mellitus (as defined by the American Diabetes Association) within the previous 24 months.

(3) History of gestational diabetes mellitus.

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

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

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

e. History of diabetes insipidus.

f. History of primary hyperparathyroidism unless surgically corrected.

g. History of hypoparathyroidism or history of hypocalcemia that requires calcitriol.

h. Current goiter.

i. Thyroid nodule unless a solitary thyroid nodule less than 10 mm or less than 3 cm with benign histology or cytology, and that does not require ongoing surveillance.

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

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

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

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

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

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

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

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

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

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

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

p. Metabolic bone disease including but not limited to:

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

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

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

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

s. History of gout.

t. History of gender-affirming hormone therapy that fails to meet the stability criteria in Paragraphs 6.24.t.(1)-(4):

(1) Use of current medication for at least 12 months or no longer requiring such hormones as certified by a treating healthcare provider.

(2) Documentation from a treating healthcare provider that the individual is free of adverse symptoms or medication side effects while meeting the adequacy of dosing targets (laboratory and other clinical targets established by the treating provider).

(3) At least one properly timed hormone laboratory test current within 12 months that shows that the serum hormone level (total and/or free testosterone for masculinizing hormone therapy and serum estradiol for feminizing hormone therapy) is within the physiologic target range, collected after the individual has been on the current medication dose and route for at least 90 days.

(4) Affirmation from the treating provider that no additional gender-affirming treatment is anticipated, other than hormone maintenance.

6.25. RHEUMATOLOGIC CONDITIONS.

a. History of systemic lupus erythematosus.

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

c. History of rheumatoid arthritis.

d. History of Sjögren's syndrome.

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

f. History of Henoch-Schonlein Purpura occurring after the 19th birthday or within the previous 24 months.

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

h. History of fibromyalgia or myofascial pain syndrome.

i. History of chronic wide-spread pain or complex regional pain syndrome.

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

k. History of spondyloarthritis, including, but not limited to, ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis (formerly known as Reiter's disease), or spondyloarthritis associated with inflammatory bowel disease.

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

m. History of any structural connective tissue disease including, but not limited to, Ehlers-Danlos syndrome, Marfan syndrome, Pseudoxanthoma Elasticum, relapsing polychondritis, and osteogenesis imperfecta.

n. History of IgG-4 related disease.

o. History of idiopathic inflammatory myositis, including, but not limited to, polymyositis or dermatomyositis, anti-synthetase syndrome, and necrotizing myopathy.

p. History of any rheumatologic or autoimmune condition severe enough to warrantusing systemic steroids for more than 2 months or any use of other systemic immunosuppressant medications.

q. History of antiphospholipid antibody syndrome.

r. History of juvenile idiopathic arthritis or adult Still's disease.

s. History of auto-inflammatory disease or periodic fever syndromes, including, but not limited to, familial Mediterranean fever and tumor necrosis factor receptor-associated periodic syndrome (TRAPS).

6.26. NEUROLOGIC CONDITIONS.

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

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

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

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

e. History of headaches within the previous 24 months that:

(1) Were severe enough to cause the individual to miss work, school, sports, or other activities more than twice within 12 months;

(2) Required prescription medications more than twice within 12 months; or

(3) Involved the use of prophylactic medication or therapy.

f. History of complex migraines associated with neurological deficit other than scotoma.

g. History of cluster headaches.

h. History of moderate or severe brain injury.

i. History of head trauma if associated with:

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

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

(3) Persistent impairment of cognitive function;

(4) Persistent alteration of personality or behavior;

(5) Cerebral traumatic findings, including, but not limited to, epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging;

(6) Associated abscess or meningitis;

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

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

(9) Any basilar or depressed skull fracture.

j. History of mild brain injury if:

(1) The injury occurred within the previous month;

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

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

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

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

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

m. History of meningitis within the previous 12 months or with persistent neurologic defects.

n. History of paralysis, weakness, lack of coordination, or sensory disturbance or other specified paralytic syndromes, including, but not limited to, Guillain-Barre Syndrome.

o. History of chronic pain or pain syndrome (including, but not limited to, complex regional pain syndrome, amplified musculoskeletal pain syndrome (AMPS) or neuralgias).

p. Any traumatic seizure occurring after the 6th birthday, unless the applicant has been free of seizures and has not taken medication for seizures for a period of 60 months and has a normal sleep-deprived electroencephalogram and normal neurology evaluation after discontinuing seizure medications.

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

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

s. History of recurrent syncope, presyncope, or atraumatic loss of consciousness, including alterated of level of consciousness, unless the applicant has been off all relevant medication and experienced no recurrence during the previous 24 months, excluding a single episode of vasovagal reaction with identified trigger such as venipuncture.

t. History of muscular dystrophies or myopathies.

6.27. SLEEP DISORDERS.

a. Chronic insomnia as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or the use of medications or other substances to promote sleep 15 or more times over the past 12 months.

b. History of sleep-related breathing disorders, including, but not limited to, sleep apnea unless definitively treated by surgical intervention with resolution of symptoms.

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

d. Circadian rhythm disorders requiring treatment or special accommodation.

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

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

6.28. LEARNING, PSYCHIATRIC, AND BEHAVIORAL DISORDERS.

a. Attention Deficit Hyperactivity Disorder, if with:

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

(2) A history of comorbid mental disorders;

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

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

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

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

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

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

c. Autism spectrum disorders.

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

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

f. Depressive disorder if:

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

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

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

(4) Any recurrence; or

(5) Any suicidality (in accordance with Paragraph 6.28.m.).

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

h. History of conduct disorders, oppositional defiance disorders, and other behavior disorders.

i. History of personality disorder or maladaptive personality traits including reasonable suspicion for the presence of an undiagnosed personality disorder, based on:

(1) Documentation of the recurrent inability to adapt in a school, employment, or training setting that resulted in significant distress or functional impairment within the previous 24 months and that is not better accounted for by another condition; or

(2) Psychological testing revealing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency may reasonably be expected to interfere with their adjustment to the Military Services.

j. Encopresis after 13th birthday.

k. History of any eating disorder.

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

m. History of suicidality, including:

(1) Suicide attempt(s);

(2) Suicidal gesture(s);

(3) Suicidal ideation with a plan; or

(4) Any suicidal ideation within the previous 12 months.

n. History of self- harm that is endorsed, documented, or otherwise clinically suspected based on scarring.

o. History of obsessive-compulsive or related disorder(s).

p. History of trauma or stressor related disorders, including, but not limited to, post-traumatic stress disorder.

q. History of anxiety disorders if:

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

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

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

(4) Any recurrence.

(5) Any suicidality (in accordance with Paragraph 6.28.m.).

r. History of dissociative disorders.

s. History of somatic symptoms and related disorders.

t. History of gender dysphoria if:

(1) Symptomatic within the previous 18 months; or

(2) Associated with comorbid mental health disorders.

u. History of paraphilic disorders.

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

w. History of prescription with psychotropic medication within the previous 36 months, unless a shorter period is authorized in another standard.

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

y. Prior psychiatric hospitalization for any cause.

6.29. TUMORS AND MALIGNANCIES.

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

b. History of malignancy.

c. History of cutaneous malignancy, meeting criteria in Paragraph 6.21.y.

6.30. MISCELLANEOUS CONDITIONS.

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

b. History of porphyria.

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

d. History of angioedema, including hereditary angioedema.

e. History of receiving organ or tissue transplantation other than dental allograft organ or tissue transplantation other than dental or orthopedic ligament graft.

f. History of pulmonary or systemic embolism.

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

h. History of heatstroke, or recurrent heat injury or exhaustion.

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

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

k. Current use of medication for HIV pre-exposure prophylaxis (PrEP), unless the applicant provides documentation of compliance with Centers for Disease Control and Prevention HIV guidelines to include:

(1) Normal results from laboratory surveillance (at a minimum, serum creatinine, glomerular filtration rate, and 4th generation HIV test) within the previous 90 days; and

(2) Confirmation by the treating healthcare provider of medication compliance, absence of side effects, and receipt of instruction on proper use of PrEP.

l. Current use of medication(s) delivered via an injectable or transdermal mechanism (e.g., allergy immunotherapy, transdermal or injectable hormones or contraceptives) or which that otherwise require(s) refrigeration, unless there is written confirmation by the individual's treating provider that the medication or therapy can be safely postponed, discontinued, or switched to an alternative delivery system without adverse risk to the individual, if the current delivery method (or refrigeration, if applicable) is not available or not authorized during periods of training or deployment.

GLOSSARY

G.1. ACRONYMS.

ACRONYM	MEANING
AMPS	amplified musculoskeletal pain syndrome
ARMSWG	Accession and Retention Medical Standards Working Group
AV	atrioventricular
CT	computerized tomography
DASD(HSP&O)	Deputy Assistant Secretary of Defense for Health Services Policy and Oversight
DASD(MPP)	Deputy Assistant Secretary of Defense for Military Personnel Policy
dB	decibel
DD	Department of Defense (forms)
DoDI	DoD instruction
DoDMERB	DoD Medical Examination Review Board
ECG	electrocardiogram
g/dl	grams per deciliter
HIV	human immunodeficiency virus
IST	inappropriate sinus tachycardia
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dL	milligrams per deciliter
mm	millimeters
mmHg	millimeters of mercury
MRI	magnetic resonance imaging
PrEP	pre-exposure prophylaxis
POTS	postural orthostatic tachycardia syndrome
PVC	preventricular contraction
TRAPS	tumor necrosis factor receptor-associated periodic syndrome
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USMEPCOM	United States Military Entrance Processing Command

G.2. DEFINITIONS.

Unless otherwise noted, these terms and their definitions are for the purpose of this volume.

TERM	DEFINITION
504 Plan	The 504 Plan is a plan developed to ensure that a child who has a disability identified in accordance with Section 504 of the Rehabilitation Act of 1973 as amended and codified at Section 701 of Title 29, U.S.C. and is attending an elementary or secondary educational institution, receives accommodations that will ensure their academic success and access to the learning environment.
accession	An enlistment, appointment, or induction that increases the incremental strength of the Regular or Reserve Components of the Military Services. Personnel enlisted under the Delayed Entry Program are not involved in this category.
covered personnel	Individuals who have been identified as HIV positive, are asymptomatic, and who have a clinically confirmed undetectable viral load.
existed prior to service	A term used to signify there is clear and unmistakable evidence that the disease or injury, or the underlying condition producing the disease or injury, existed prior to the individual's entry into military service.
gender identity	An individual's internal or personal sense of gender, which may or may not match the individual's biological sex.
induction	Transition from civilian to military status for a period of definite military obligation in accordance with Chapter 49 of Title 50, U.S.C., also known as the "Military Selective Service Act."
medical waiver	A formal request to consider the suitability for service of an applicant who, because of current or past medical conditions, does not meet medical standards. Upon the completion of a thorough review, the applicant may be considered for a waiver. The applicant must have displayed sufficient mitigating circumstances/provided medical documentation that clearly justify waiver consideration. The Secretaries of the Military Departments may delegate the final approval authority for all waivers.
MEDPERS	Includes leaders from the DoD medical and personnel communities to develop, discuss, and make decisions about common medical issues that require resolution. The primary focus is the nexus of medical and personnel systems that impact the total force, including

TERM	DEFINITION
	those seeking entry into the armed forces and those who must depart prior to completion of an enlistment or career.
Military Department	Defined in the DoD Dictionary of Military and Associated Terms.
National Heart, Lung, and Blood Institute	An agency within the National Institutes of Health that provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.
stress reaction	Defined in UpToDate Overview of Stress Fractures.
treating healthcare provider	A licensed provider working within their scope of practice who assumes responsibility for management, treatment or ongoing care of a patient.

REFERENCES

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American Diabetes Association, "Diagnosis and Classification of Diabetes Mellitus," current edition

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American National Standards Institute S3.6-2010, "Specification for Audiometers," current edition[1]

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DoD 5400.11-R, "Department of Defense Privacy Program" May 14, 2007

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DoD Instruction 1350.02, "DoD Military Equal Opportunity Program," September 4, 2020

DoD Instruction 5400.11, "DoD Privacy and Civil Liberties Programs" January 29, 2019, as amended

DoD Instruction 6130.03, Volume 2, "Medical Standards for Military Service: Retention," September 4, 2020, as amended

DoD Manual 8910.01, Volume 2, "DoD Information Collections Manual: Procedures for DoD Public Information Collections," June 30, 2014, as amended

International Classification of Diseases, Tenth Revision, Clinical Modification[6]

National Heart, Lung, and Blood Institute and American Heart Association Scientific Statement, "Diagnosis and management of the metabolic syndrome," October 25, 2005

Office of the Chairman of the Joint Chiefs of Staff, "DoD Dictionary of Military and Associated Terms," current edition

Under Secretary of Defense for Personnel and Readiness, Medical and Personnel Executive Steering Committee Charter, September 2012

United States Code, Title 10

1 Available for purchase at http://www.ansi.org/

2 Available at https://www.cdc.gov/hiv/guidelines/index.html

3 Available at https://www.cdc.gov/tb/publications/guidelines/default.htm

4 Available at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo

5 Available at https://www.uptodate.com/contents/overview-of-stress-fractures

6 Available at http://www.cdc.gov/nchs/icd/icd10cm.htm#icd2016.

United States Code, Title 18, Section 1001
United States Code, Title 29, Section 701 (also known as the "Rehabilitation Act of 1973")
United States Code, Title 50, Chapter 49 (also known as the "Military Selective Service Act")

Exhibit 3

DoDI 6485.01

Department of Defense

INSTRUCTION

NUMBER 6485.01
June 7, 2013
Incorporating Change 2, Effective June 6, 2022

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 (other than covered personnel who are seeking to commission while a Service member), 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. **Cleared for public release.** This instruction is available on the Directives Division Website at https://www.esd.whs.mil/DD/.

7. SUMMARY OF CHANGE 2. In accordance with the June 6, 2022 Secretary of Defense Memorandum (Reference (m)), the changes to this issuance update DoD policy with respect to individuals who have been identified as HIV-positive. Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV-positive status.

8. EFFECTIVE DATE. This instruction is effective June 7, 2013.

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

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2. Responsibilities
3. Procedures

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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," May 6, 2018
(d) DoD Directive 6490.02E, "Comprehensive Health Surveillance," February 8, 2012, as amended
(e) DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014
(f) DoD Instruction 6490.03, "Deployment Health," June 19, 2019
(g) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011, as amended
(h) DoD Instruction 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010
(i) DoD Instruction 1332.18, "Disability Evaluation System (DES)," August 5, 2014, as amended
(j) Section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986
(k) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
(l) DoD 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs," March 13, 2019
(m) Secretary of Defense Memorandum, "Policy Regarding Human Immunodeficiency Virus-Positive Personnel within the Armed Forces," June 6, 2022

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 (d)).

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 (e)) and DoDI 6490.03 (Reference (f)).

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

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 (References (g).

b. In accordance with DoDI 6490.07 (Reference (h)), 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 1332.18 (Reference (i)). 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 (i).

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 (j)). 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 Manual 6025.18 (References (k) and (l)).

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.

covered personnel. Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load.

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 4

DoDI 6130.03, Vol. 2

DoD INSTRUCTION 6130.03, VOLUME 2

MEDICAL STANDARDS FOR MILITARY SERVICE: RETENTION

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective:	September 4, 2020
Change 1 Effective	June 6, 2022
Releasability:	Cleared for public release. Available on the Directives Division Website at https://www.esd.whs.mil/DD/.
Approved by:	Matthew P. Donovan, Under Secretary of Defense for Personnel and Readiness
Change 1 Approved by:	Lloyd J. Austin III, Secretary of Defense

Purpose: This instruction is composed of two volumes, each containing its own purpose. In accordance with the authority in DoD Directive 5124.02:

- This instruction establishes policy, assigns responsibilities, and prescribes procedures for medical standards for the Military Services.
- This volume establishes medical retention standards and the Retention Medical Standards Working Group (RMSWG), under the Medical and Personnel Executive Steering Committee (MEDPERS), to provide policy recommendations related to this instruction.

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This volume applies to OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), 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 (referred to collectively in this volume as the "DoD Components").

b. Gender dysphoria-related standards in this volume do not apply to Service members considered exempt pursuant to DoDI 1300.28.

1.2. POLICY.

It is DoD policy that:

a. Service members meet DoD medical standards established in this volume to be retained in the Military Services.

b. Service members who are unable to successfully complete their assigned duties while deployed, stationed with only operational healthcare unit support, or while in garrison conditions, be referred to:

(1) The Disability Evaluation System (DES), on a case-by-case basis, in accordance with DoD Instruction (DoDI) 1332.18 and DoDI 1332.45; or

(2) For conditions not constituting a disability, the responsible Military Department for possible administrative action, in accordance with DoDI 1332.14 or DoDI 1332.30.

c. DoD medical standards for military retention are consistent with:

(1) The criteria for DES referral, in accordance with DoDI 1332.18 and other military requirements, as further defined in Paragraph 3.2 of this volume.

(2) Deployment requirements, as defined in DoDI 6490.07, and a broader definition of deployability, as defined in DoDI 1332.18.

(3) Retention determinations for certain non-deployable Service members in accordance with DoDI 1332.45.

(4) Military Health System (MHS) efforts to improve performance, economy, and efficiency.

d. Additional, more selective medical standards for military retention may be established by the Secretaries of the Military Departments based on the Service member's office, grade, rank, or rating, as long as such standards are objectively applied and are not inconsistent with applicable laws or DoD policies.

1.3. SUMMARY OF CHANGE 1.

In accordance with the June 6, 2022 Secretary of Defense memorandum, the changes to this issuance update DoD policy with respect to individuals who have been identified as HIV-positive. Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV-positive status.

SECTION 2: RESPONSIBILITIES

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

The USD(P&R):

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

b. Maintains and convenes the chartered MEDPERS, in accordance with Volume 1 of this instruction.

2.2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)).

Under the authority, direction, and control of the USD(P&R), the ASD(HA):

a. Reviews, approves, and issues technical modifications to the standards in Section 5 to the DoD Components.

b. Reviews implementation of medical standards for military retention throughout the MHS and provides guidance to the Director, Defense Health Agency (DHA) and the Secretaries of the Military Departments.

2.3. DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH SERVICES POLICY AND OVERSIGHT (DASD(HSP&O)).

Under the authority, direction, and control of the ASD(HA), the DASD(HSP&O):

a. Reviews the standards in Section 5, associated Service-specific regulations, and Service-specific medical standards for retention, in terms of performance, economy, and efficiency throughout the MHS, and provides appropriate policy recommendations to the ASD(HA).

b. Coordinates revisions to policies related to this volume with relevant DoD Components.

c. Selects a co-chair for the RMSWG and requires records of the RMSWG be maintained and retained, in accordance with all legal requirements.

2.4. DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR MILITARY PERSONNEL POLICY (DASD(MPP)).

Under the authority, direction, and control of the ASD(M&RA), the DASD(MPP):

a. Coordinates revisions to policies related to this volume with relevant DoD Components.

b. Selects a co-chair for the RMSWG.

2.5. DIRECTOR, DHA.

Under the authority, direction, and control of the USD(P&R), through the ASD(HA), the Director, DHA:

a. Publishes DHA procedural instructions necessary to implement this volume.

b. Uses the planning, programing, budgeting, and execution process to allocate resources necessary for the evaluation of medical conditions, in accordance with this volume and Service-specific medical standards for military retention.

c. Supports MHS efforts to monitor and improve medical standards for military retention.

d. Selects a representative for the RMSWG.

2.6. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD (USCG).

The Secretaries of the Military Departments and the Commandant, USCG:

a. Provide guidance necessary to implement this volume and Service-specific retention medical standards, as required, to refer Service members to the:

(1) DES, in accordance with DoDI 1332.18, DoDI 1332.45, and this volume; or

(2) For members of the USCG, the USCG Physical DES, pursuant to the Commandant Instruction M1850.2 series.

b. Select a representative for the RMSWG.

SECTION 3: PROCEDURES FOR APPLYING MEDICAL STANDARDS

3.1. APPLICABILITY OF RETENTION MEDICAL STANDARDS.

The medical standards in Section 5 apply to:

a. All current Service members, including those:

(1) Accessed with a medical waiver in accordance with Volume 1 of this instruction and DoDI 1332.18.

(2) Previously found fit by the DES, in accordance with DoDI 1332.18, when the condition progresses and has become potentially unfitting.

b. Former Service members being medically evaluated for return to military service when the applicability criteria in Paragraph 4.1 of Volume 1 of this instruction does not apply.

3.2. APPLICATION OF CRITERIA USED TO DEVELOP STANDARDS.

The standards in Section 5 will be applied on a case-by-case basis considering the following criteria:

a. The affected Service member's ability to safely complete common military tasks at a general duty level. Tasks may include, but are not limited to:

(1) Climbing and going down structures such as stairs, a ladder, ladderwells, or a cargo net.

(2) Wearing personal protective gear.

(3) Running 100 yards.

(4) Standing in formation.

(5) Carrying personal equipment.

(6) Operating a vehicle.

(7) Operating an assigned weapons system, to include safe operation of an individual firearm.

(8) Subsisting on field rations.

(9) Working in extreme environments or confined spaces.

(10) Operating for extended work periods.

(11) Communicating effectively.

b. Limitations or requirements due to medical condition(s) or objections to recommended medical interventions that:

(1) Impose unreasonable medical requirements on the Military Services to maintain or protect the Service member.

(2) Require diagnostic(s), treatment(s), or surveillance for longer than 12 months that is not anticipated to be routinely available in operational locations, unless approved by the Service member's unit commander in accordance with DoDI 1332.45.

(3) Present an obvious risk to the health or safety of the member, other Service members, or other personnel serving with or accompanying an armed force in the field.

(4) Are of such a nature or duration that progressive worsening or effects of external stressors are reasonably expected to result in a grave medical outcome or an unacceptable negative impact on mission execution.

(5) Are incompatible with the physical and psychological demands required for deployment and the Service member's office, grade, rank, or rating.

3.3. IMPLEMENTATION.

a. The Military Department(s) concerned will:

(1) Apply the standards in Section 5 on a case-by-case basis.

(2) Consider which criteria in Paragraph 3.2. apply to the Service member's office, grade, rank, or rating.

(3) Determine if the Service member should be referred to the DES.

(4) Perform these evaluations in accordance with Service-specific regulations before or during the medical evaluation board component of the DES process.

b. Service members will be referred to the DES in accordance with DoDI 1332.18. The standards listed in Section 5 do not include all of the conditions that may be referred to the DES or that are compensable in accordance with Part 4 of Title 38, Code of Federal Regulations also known as "the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD)". In the event of conflicting guidance or lack of a defined standard in this volume, DoDI 1332.18 will take precedence.

c. Military Departments may authorize administrative separation processing of Service members with medical conditions and circumstances not constituting a physical disability, in accordance with DoDI 1332.14 or DoDI 1332.30, that interfere with assignment or performance

of duty, if the Service member is ineligible for referral to the DES, pursuant to DoDI 1332.18, or the USCG Physical DES, pursuant to the Commandant Instruction M1850.2 series.

d. Military Department regulations regarding presumption of fitness are considered by medical and administrative personnel when applying the standards in Section 5.

e. Medical diagnoses and duty limitations will be made in conjunction with referrals or information provided by the appropriate medical specialty, in accordance with this volume and Military Service-specific regulations.

f. Military Departments will coordinate requirements for clinical evaluations, information technology, and access to medical records with the Director, DHA.

g. If a Service member fails to consent to medically appropriate treatment for a potentially disqualifying condition, the condition is considered refractory to treatment and may result in the Service member not being eligible for retention. The Military Department concerned will take appropriate administrative action in accordance with Military Department-specific policies.

SECTION 4: ACTIVITIES OF THE RMSWG

4.1. PURPOSE OF THE RMSWG.

The RMSWG—a chartered working group under the MEDPERS—convenes at least twice a year, under the joint guidance of the DASD(HSP&O) and the DASD(MPP), to review and develop policy relevant to this volume.

4.2. OVERALL GOALS OF THE RMSWG.

The RMSWG will:

a. Review and develop proposed changes to this volume in accordance with DoDI 5025.01.

b. Draft DoD medical standards for military retention based on DoD mission requirements, available scientific evidence, and expert opinion.

c. Evaluate DoD Component implementation of the standards in Section 5 of this volume.

d. Respond to requests from the MEDPERS.

e. Periodically reassess the goals of the RMSWG.

4.3. CO-CHAIRS OF THE RMSWG.

The DASD(HSP&O) and the DASD(MPP) will each select one representative to co-chair the RMSWG. The RMSWG co-chairs will:

a. Draft the RMSWG charter for MEDPERS approval.

b. Record and retain meeting minutes and other committee records.

c. Schedule meetings as required.

4.4. MEMBERSHIP OF THE RMSWG.

The RMSWG membership will include medical and personnel representatives from:

a. Each Military Service.

b. The Joint Staff.

c. Other organizations as required in accordance with the RMSWG charter.

SECTION 5: DISQUALIFYING CONDITIONS

5.1. GENERAL.

The medical standards for military retention are classified into general systems in this section. Unless otherwise stipulated, these are the conditions that do not meet the retention standard. These conditions must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

5.2. HEAD.

Defects of the skull, face, or mandible to a degree that prevents the member from properly wearing required protective equipment (e.g., military headgear) are not compatible with retention. The condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

5.3. EYES.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

b. Any chronic disease process or condition of the eye, lids, or visual system that is resistant to treatment and does not meet the vision standards in Paragraph 5.4.

c. Corneal degeneration, when contact lenses or other special corrective devices (e.g., telescopic lenses, electronic magnifiers) are required to prevent progression or to meet the standards in Paragraph 5.4.

d. Aphakia, bilateral if not a surgical candidate. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.3.a does not apply.

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

f. Bilateral concentric constriction to less than 40 degrees interfering with the ability to safely perform duty.

g. Absence of an eye or enucleation. This condition is not compatible with retention and the Services should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.3.a. does not apply.

h. Night blindness requiring assistance to travel at night or resulting in duty limitations due to an inability to perform night missions.

i. Any chronic eye diseases requiring treatment with systemic immunosuppressant medication.

5.4. VISION.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Vision standards must be met with the unaided eye or clear glasses without specialized optical aids including, but not limited to, telescopic, magnifying, or tinted lenses (excluding sunglasses for routine wear). Color vision standards will be set by the individual DoD Components.

a. With both eyes open, best corrected for both distant and near vision of at least 20/40.

b. Any condition that specifically requires contact lenses for correction of vision.

c. Anisometropia worse than 3.5 diopters (spherical equivalent difference).

d. Any scotoma large enough to impair duty performance including, but not limited to, permanent hemianopsia.

5.5. EARS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. Persistent defect that prevents the proper wearing of required military equipment (e.g., hearing protection).

b. Ménière's disease and other disorders of balance or sensorium with frequent and severe attacks that interfere with satisfactory performance of duty.

c. Any conditions of the ear that persist despite appropriate treatment and necessitate frequent and prolonged medical care or hospitalization (e.g., cholesteatoma, chronic otitis infections, and associated secondary changes).

5.6. HEARING.

Hearing loss that prohibits safe performance of duty, with or without hearing aids or other assistive devices is not compatible with retention. The condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

5.7. NOSE, SINUSES, MOUTH, AND LARYNX.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. Vocal cord dysfunction characterized by bilateral vocal cord paralysis or dysfunction significant enough to interfere with speech or cause respiratory compromise upon exertion.

b. Any persistent condition of the sinuses or nasal cavity that requires ongoing medical care beyond operationally available maintenance medications to maintain sinonasal function.

c. Conditions or defects of the mouth, tongue, palate, throat, pharynx, larynx, and nose that interfere with chewing, swallowing, speech, or breathing.

5.8. DENTAL.

Diseases and abnormalities of the jaw or associated tissues that prevent normal mastication, speech, or proper wear of required protective equipment are not compatible with retention. The condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

5.9. NECK.

Limited range of motion of the neck that impairs normal function is not compatible with retention. The condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

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

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Conditions in this paragraph do not meet the standards if the Service member cannot meet Service-specific pulmonary functional assessment (e.g., trial of duty or established standard) or if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Asthma or airway hyper responsiveness with:

(1) Persistent symptoms;

(2) Forced expiratory volume in one second (FEV1) persistently below 70 percent despite treatment with inhaled corticosteroids; or

(3) More than once required oral steroid or emergent asthma treatment in the previous 12 months.

b. Chronic obstructive pulmonary disease with:

(1) Persistent symptoms;

(2) FEV1 between 50 percent and 79 percent of predicted FEV1 that cannot pass Service-determined functional assessments;

(3) FEV1 of less than 50 percent of predicted FEV1, despite treatment with inhaled corticosteroids; or

(4) More than one required hospitalization in the previous 12 months.

c. Bronchiectasis, if severe or symptomatic.

d. Thoracic cavity malformation or dysfunction, including pectus excavatum, pectus carinatum, or diaphragmagtic defect, if it is symptomatic or interferes with the wearing of military equipment or the performance of military duty.

e. Chronic or recurrent pulmonary disease or symptoms including, but not limited to:

(1) Pulmonary fibrosis;

(2) Emphysema;

(3) Interstitial lung disease;

(4) Pulmonary sarcoidosis;

(5) Pleurisy; or

(6) Residuals of surgery that prevent satisfactory performance of duty.

f. Recurrent spontaneous pneumothorax, when the underlying defect is not correctable by surgery.

g. Tuberculosis, pulmonary or extra pulmonary, with clinically significant sequelae following treatment, if resistant to treatment or if the condition is of such severity that the individual is not expected to return to full duty despite appropriate treatment.

h. Pulmonary embolism, recurrent or a single episode, if anticoagulation medications, other than aspirin, are clinically indicated for longer than 12 months.

i. Cystic fibrosis.

j. Any condition for which chronic use of supplemental oxygen is indicated.

5.11. HEART.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Conditions in this paragraph do not meet the standards if the Service member cannot meet Service-specific cardiac functional assessment (e.g., a Service-defined trial of duty period) or if medical clearance cannot be given for safe participation in Service-specific physical fitness testing due to risk of disease progression or adverse cardiac event.

b. Heart valve disease; including:

(1) Any valve replacement. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions after post-operative recovery (or a period of Limited Duty). Paragraph 5.11.a does not apply.

(2) Moderate or worse valvular insufficiency or regurgitation if a cardiologist determines that the Service member has physical activity or duty restrictions to reduce the risk of disease progression or an adverse cardiac event.

(3) Mild or worse valvular stenosis if a cardiologist determines the Service member has physical activity or duty restrictions to reduce the risk of disease progression or adverse cardiac event.

c. Cardiomyopathy or heart failure; including:

(1) Persistent cardiomyopathy or heart failure related to a potentially reversible condition when a cardiologist determines that the underlying etiology is uncorrectable.

(2) Cardiomyopathy or heart failure, upon diagnosis, when secondary to an underlying permanent condition including, but not limited to: hypertrophic cardiomyopathy, amyloidosis, sarcoidosis, ventricular non-compaction syndrome, and arrhythmogenic right ventricular cardiomyopathy. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.11.a does not apply.

d. Clinical indication or presence of pacemaker or implantable cardioverter-defibrillator. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.11.a does not apply.

e. Atrial and ventricular arrhythmias, other than isolated Premature Ventricular Contractions and Premature Atrial Contractions, unless successfully ablated (if indicated) and cleared by a cardiologist for unrestricted exercise.

f. Channelopathies reliably diagnosed by a cardiologist that predisposes to sudden cardiac death and syncope including, but not limited to:

(1) Brugada pattern;

(2) Acquired or Congenital Long QT syndrome; or

(3) Catecholiminergic Polymorphic Ventricular Tachycardia. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.11.a does not apply.

g. Pre-excitation pattern (e.g., Wolff-Parkinson-White pattern) unless it is asymptomatic and associated with low-risk accessory pathway by appropriate diagnostic testing, or successfully treated with ablation.

h. Conduction disorders associated with potentially fatal or severely symptomatic events including, but not limited to:

(1) Disorders of sinus arrest;

(2) Asystole;

(3) Mobitz type II second-degree atrioventricular block;

(4) Third-degree atrioventricular block; or

(5) Sudden cardiac death unless associated with recognizable temporary precipitating conditions (e.g., perioperative period, hypoxia, electrolyte disturbance, drug toxicity, infection, or acute illness). This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.11.a does not apply.

i. Coronary artery disease; including:

(1) Acute Coronary Syndrome (ST-elevation myocardial infarction or Non-ST elevation myocardial infarction):

(a) That required intervention including, but not limited to:

1. Percutaneous coronary intervention;

2. Coronary artery bypass grafting; or

3. Thrombolytic medication.

(b) For which anti-platelet therapy, other than aspirin, occurs for longer than 12 months.

(2) Stable coronary disease, unless there is no evidence of ischemia and the Service member can achieve 10 metabolic equivalents while on optimal medical therapy.

j. Chronic pericardial disease, reliably diagnosed by a cardiologist.

k. Complex congenital heart disease including, but not limited to: tetrology of Fallot, coarctation of the aorta, and Ebstein's anomaly, unless successfully treated by surgical or percutaneous correction.

l. Symptomatic or hemodynamically significant anatomic intracardiac shunts including, but not limited to: patent foramen ovale, atrial septal defect, and ventricular septal defect, if persistent despite surgical or percutaneous correction (as indicated).

m. Recurrent syncope or near syncope (including postural orthostatic tachycardia syndrome) that interferes with duty, if no treatable cause is identified or it persists despite conservative therapy.

n. Rheumatic heart disease, if sequelae present.

o. History of spontaneous coronary artery dissection.

p. Surgery of the heart or pericardium with persistent duty limitations.

5.12. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions in this paragraph do not meet retention standards if associated with the inability to maintain normal weight or nutrition, require repeated procedures or surgery, or if the condition requires immunomodulating or immunosuppressant medications.

a. Esophageal stricture, including manifestations of eosinophilic esophagitis, that requires a restricted diet or frequent dilatation.

b. Persistent esophageal disease (e.g., dysmotility disorders, achalasia, esophagitis, esophageal spasm) that is severe, or results in dysphagia.

c. Gastritis, if severe, with recurring symptoms not relieved by medication, surgery, or endoscopic intervention.

d. Non-ulcerative or functional dyspepsia not controlled by medications.

e. Recurrent gastric or duodenal ulcer, with or without obstruction or perforation confirmed by laboratory, imaging, or endoscopy.

f. Inflammatory bowel disease including, but not limited to:

(1) Crohn's disease;

(2) Ulcerative colitis;

(3) Ulcerative proctitis;

(4) Regional enteritis;

(5) Granulomatous enteritis;

(6) Chronic or recurrent indeterminate colitis; or

(7) Microscopic colitis that requires treatment with immune modulator or biologic medications.

g. Chronic proctitis with moderate to severe symptoms of bleeding, painful defecation, tenesmus, or diarrhea.

h. Malabsorption syndromes including those related to:

(1) Celiac sprue;

(2) Pancreatic insufficiency; or

(3) Sequelae of surgery including, but not limited to:

(a) Bariatric surgery;

(b) Colectomy; or

(c) Gastrectomy.

i. Functional gastrointestinal disorders, including but not limited to irritable bowel syndrome.

j. Familial adenomatous polyposis syndrome (e.g., classic or attenuated) or hereditary non-polyposis colon cancer (i.e., Lynch syndrome).

k. Chronic hepatitis with impairment of liver function.

l. Cirrhosis of the liver, portal hypertension, esophageal varices, esophageal bleeding, or other complications of chronic liver disease, resulting from conditions including, but not limited to:

(1) Hemochromatosis.

(2) Alpha-1 anti-trypsin deficiency.

(3) Wilson's disease.

(4) Alcoholic and non-alcoholic fatty liver disease.

m. Chronic gallbladder disease or biliary dyskinesia with frequent abdominal pain or recurrent jaundice.

n. Chronic liver disease because of trauma or infection, to include amoebic abscess or liver transplant recipient(s).

o. Chronic or recurrent pancreatitis.

p. Pancreatectomy or pancreas (whole organ or islet cell) transplant recipient(s).

q. Pancreaticduodenostomy, pancreaticgastrostomy, or pancreaticojejunostomy, with chronic digestive system dysfunction.

r. Acquired fecal incontinence or obstruction characterized by intractable constipation or pain on defecation.

s. Severe symptomatic hernia, including abdominal wall or hiatal.

t. Total colectomy or any partial colectomy with residual limitations.

u. Total gastrectomy, or any partial gastroectomy or gastrojejunostomy with residual limitations.

v. Colostomy, jejunostomy, ileostomy, or gastrostomy, if permanent.

5.13. FEMALE GENITAL SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. Genital trauma or abnormalities that result in urinary incontinence or the need for catheterization.

b. Chronic pelvic pain, with or without an identifiable diagnosis, such as dysmenorrhea, endometriosis, or ovarian cysts.

c. Premenstrual dysphoric disorder.

d. Abnormal uterine bleeding resulting in anemia.

e. Chronic breast pain, so as to prevent satisfactory wearing of military equipment.

5.14. MALE GENITAL SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. Absence of both testicles with medically required injectable hormone therapy.

b. Epispadias or hypospadias when accompanied by persistent urinary complications.

c. Chronic pelvic pain, with or without an identifiable diagnosis, to include chronic prostatitis, epididymitis, scrotal pain, or orchitis.

d. Genital trauma or abnormalities that result in urinary incontinence or the need for catheterization.

5.15. URINARY SYSTEM.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

b. Chronic or interstitial cystitis.

c. Chronic incontinence, dysfunction, or urinary retention requiring catheterization.

d. Cystoplasty, if reconstruction is unsatisfactory or if refractory symptomatic infections persist.

e. Ureterointestinal or direct cutaneous urinary diversion.

f. Urethral abnormalities, if they:

(1) Result in chronic incontinence;

(2) Result in the persistent need for catheterization; or

(3) Require a urethrostomy, if a satisfactory urethra cannot be restored.

g. Ureteral abnormalities, including ureterocystostomy, if both ureters are markedly dilated with irreversible changes, or if they result in:

(1) Recurrent obstruction;

(2) Kidney infection; or

(3) Other chronic kidney dysfunction.

h. Kidney transplant recipient(s). This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.15.a. does not apply.

i. Chronic or recurrent pyelonephritis with secondary hypertension or hypertensive end-organ damage.

j. Kidney abnormalities, including:

(1) Polycystic kidney disease;

(2) Horseshoe kidney;

(3) Hypoplasia of the kidney; or

(4) Residuals of perirenal abscess when renal function is:

(a) Impaired;

(b) Associated with secondary hypertension or hypertensive end-organ damage; or

(c) The focus of frequent infection.

k. Hydronephrosis associated with significant systemic effects, renal impairment, secondary hypertension, hypertensive end-organ damage, or frequent infections.

l. Chronic kidney disease, stage 3A or worse, according to the Kidney Disease Improving Global Outcomes Guidelines Standard, as reliably diagnosed by a nephrologist. Any level of chronic kidney disease for which chronic immunosuppressant medications (e.g., medication for steroid relapsing glomerulonephritis) are required. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.15.a does not apply.

m. Chronic nephritis or nephrotic syndrome. Service-specific criteria for proteinuria may apply.

n. Recurrent calculi that:

(1) Result in recurring infections;

(2) Result in obstructive uropathy unresponsive to medical or surgical treatment; or

(3) Are symptomatic and occur with a frequency that prevents satisfactory performance of duty.

5.16. SPINE AND SACROILIAC JOINT CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Conditions in this paragraph do not meet retention standards if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Spondyloarthritis. Chronic or recurring episodes of axial or peripheral arthritis that may include extra-articular involvement that:

(1) Causes functional impairment interfering with successful performance of duty supported by objective, subjective, and radiographic findings; or

(2) Requires medication for control that needs frequent monitoring by a physician due to debilitating or serious side effects including, but not limited to:

(a) Ankylosing spondylitis;

(b) Reactive arthritis;

(c) Psoriatic arthritis; or

(d) Arthritis associated with inflammatory bowel disease.

b. Radicular or non-radicular pain involving the cervical, thoracic, lumbosacral, or coccygeal spine, whether idiopathic or secondary to degenerative disc or joint disease.

c. Kyphosis:

(1) Resulting in greater than 50 degrees of curvature, if symptomatic, so as to limit the wearing of military equipment; or

(2) If recurrently symptomatic, regardless of the degree of curvature.

d. Scoliosis:

(1) Resulting in severe deformity—greater than 30 degrees of curvature—if symptomatic, so as to limit the wearing of military equipment; or

(2) If recurrently symptomatic, regardless of the degree of curvature.

e. Congenital or surgical fusion or disc replacement.

f. Vertebral fractures after radiographic evidence of complete healing and experiencing moderate or severe symptoms that result in repeated acute medical visits.

g. Spina bifida with demonstrable signs and moderate symptoms of root or cord involvement.

h. Spondylolysis or spondylolisthesis with moderate or severe symptoms resulting in repeated acute medical visits.

5.17. UPPER EXTREMITY CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Conditions in this

paragraph do not meet retention standards if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Limitation of joint motion.

b. Amputation of any part of hand and fingers.

c. Intrinsic paralysis or weakness of upper limbs when symptoms are severe and persistent.

5.18. LOWER EXTREMITY CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions in this paragraph do not meet retention standards if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Limitation of joint motion.

b. Foot and ankle conditions that include:

(1) Amputation of any part of the foot or toes.

(2) Conditions of the foot or toes that prevent the satisfactory performance of required military duty or the wearing of required military footwear, such as:

(a) Deformity of the toes;

(b) Clubfoot;

(c) Rigid pes planus;

(d) Recurrent plantar fasciitis; or

(e) Symptomatic neuroma.

c. Chronic foot, leg, knee, thigh, and hip conditions, such as:

(1) Chronic anterior knee pain;

(2) Instability after knee ligament reconstruction; or

(3) Recurrent stress fracture.

d. Coxa vara to such a degree that it results in chronic pain.

5.19. GENERALIZED CONDITIONS OF THE MUSCULOSKELETAL SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions in this paragraph do not meet retention standards if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Persistent symptoms after any dislocation, subluxation, or instability of the hip, knee, ankle, subtalar joint, foot, shoulder, hand, wrist, or elbow.

b. Osteoarthritis or infectious arthritis with severe symptoms or traumatic arthritis.

c. Malunion, non-union, or hypertrophic ossification with persistent severe deformity or loss of function.

d. Prosthetic replacement of any joints, if there is resultant loss of function or persistent pain.

e. History of neuromuscular paralysis, weakness, contracture, or atrophy that is not completely resolved.

f. Osteopenia, osteoporosis, or osteomalacia resulting in fracture with residual symptoms after therapy.

g. Recurrent episodes of chronic osteomyelitis that:

(1) Are not responsive to treatment; or

(2) Involve the bone to a degree that interferes with stability and function.

h. Osteonecrosis, to include avascular necrosis of bone.

i. Chronic tendonitis, tenosynovitis, or tendinopathy.

j. Osteitis deformans (i.e., Paget's disease) that involve single or multiple bones and result in deformities or symptoms that severely interfere with function.

k. Chronic mechanical low back pain.

5.20. VASCULAR SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

a. Abnormalities of the arteries including, but not limited to, aneurysms, arteriovenous malformations, or arteritis.

b. Peripheral artery disease including claudication and renal artery stenosis.

c. Hypertensive cardiovascular disease and hypertensive vascular disease.

(1) Essential hypertension that:

(a) Is not controlled despite an adequate period of therapy in an ambulatory status;

(b) Is associated with end organ damage; or

(c) Requires a treatment regimen that is not compatible with an operational environment.

(2) Secondary hypertension, unless the underlying cause has been treated with subsequent control of blood pressure.

d. Persistent peripheral vascular disease.

e. Venous disease that, despite appropriate treatment, results in:

(1) Persistent duty limitations.

(2) Limitations in the wearing of the military uniform.

f. Deep vein thrombosis (recurrent or a single episode), if anticoagulation medications, other than aspirin, are clinically indicated for longer than 12 months.

g. Surgery of the vascular system with persistent duty limitations.

h. Thoracic Outlet Syndrome including:

(1) Thoracic Outlet Syndrome—either neurogenic, arterial, or venous:

(a) With symptoms that are not controlled, despite an adequate period of therapy and surgery;

(b) That is associated with end organ damage, or

(c) That requires anticoagulation medication other than aspirin.

(2) Venous Thoracic Outlet Syndrome that required venous reconstruction with a stent or open surgery.

(3) Arterial Thoracic Outlet Syndrome that required arterial reconstruction with a bypass or interposition graft.

i. Popliteal Entrapment Syndrome:

(1) With symptoms that are not controlled despite an adequate period of therapy and surgery, is associated with end organ damage, or requires anticoagulation medication other than aspirin.

(2) That required arterial reconstruction with a bypass or interposition graft.

5.21. SKIN AND SOFT TISSUE CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions in this paragraph do not meet standard if the Service member cannot properly wear the required military uniform or equipment.

a. Skin or soft tissue conditions, such as:

(1) Severe nodulocystic acne;

(2) Hidradenitis suppurativa;

(3) Inflammatory or scarring scalp disorders;

(4) Bullous dermatoses (including, but not limited to, dermatitis herpetiformis, emphigus, and epidermolysis bullosa);

(5) Lichen planus; or

(6) Panniculitis that prevents the proper wearing required military uniform or equipment.

b. Severe atopic dermatitis that prevents the proper wearing of required military uniform or equipment.

c. Any dermatitis, including eczematous or exfoliative, that prevents the proper wearing of required military uniform or equipment.

d. Persistent or recurrent symptomatic cysts, including pilonidal cysts or furunculosis, that prevent the proper wearing of required military uniform or equipment.

e. Chronic or current lymphedema.

f. Severe hyperhidrosis.

g. Scars or keloids that:

(1) Prevent the proper wearing of required military uniform or equipment; or

(2) Interfere with the function of an extremity or body area, including by limiting range of motion or causing chronic pain.

h. Neurofibromatosis, other than cutaneous neurofibromas.

i. Psoriasis or parapsoriasis that is uncontrolled or requires:

(1) Systemic immunomodulating;

(2) Immunosuppressant medications; or

(3) Ultraviolet light therapy.

j. Scleroderma that seriously interferes with the function of an extremity or body area.

k. Chronic urticaria or angioedema that is not responsive to treatment or requires duty limitations despite appropriate treatment.

l. Intractable symptomatic plantar keratosis.

m. Intractable superficial or deep fungal infections.

n. Malignant neoplasms (refer to Paragraph 5.29 for malignancies):

(1) Including melanoma, melanoma in situ, and cutaneous lymphoma (mycosis fungoides).

(2) Not including basal cell and squamous cell carcinomas.

o. Any photosensitive dermatosis, including, but not limited to:

(1) Cutaneous lupus erythematosus;

(2) Dermatomyositis;

(3) Polymorphous light eruption; or

(4) Solar urticaria.

p. Severe or chronic erythema multiforme.

q. Chronic, non-healing ulcers of the skin.

5.22. BLOOD AND BLOOD FORMING CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

a. Anemia, hereditary or acquired, when:

(1) Response to therapy is unsatisfactory; or

(2) Therapy requires prolonged, intensive, medical supervision or intervention.

b. Hypercoagulable disease associated with vascular thrombosis when anticoagulation medication of any type (except aspirin) is clinically indicated for longer than 12 months.

c. Bleeding disorders including, but not limited to:

(1) Hemophilia or other clinically significant factor deficiencies;

(2) Thrombocytopenia with persistent platelet count less than 50,000;

(3) Clinically significant Von Willebrand disease; or

(4) Platelet function disorders.

d. Chronic leukopenia:

(1) If therapy is clinically indicated due to a malignant process; or

(2) Where therapy is indicated for longer than 12 months.

e. Primary Polycythemia Vera, Essential Thrombocytosis, or Chronic Myelogenous Leukemia, if therapy beyond aspirin is clinically indicated.

f. Chronic and clinically significant splenomegaly.

g. Chronic or recurrent symptomatic hemolytic crisis.

5.23. SYSTEMIC CONDITIONS.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions listed in this paragraph do not meet medical retention standards if they require medication for control with frequent monitoring by a medical provider due to potential debilitating or serious side effects.

b. Disorders involving the immune system, including immunodeficiencies with progressive clinical illness.

(1) A Service member with laboratory evidence of Human Immunodeficiency Virus 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, including evaluation on a case-by-case basis. Covered personnel will not be discharged or separated solely on the basis of their HIV-positive status.

(2) Primary immunodeficiencies—including, but not limited to, hypogammaglobulinemia, common variable immune deficiency, or complement deficiency—with objective evidence of function deficiency and severe symptoms that are not controlled with treatment, or when injectable medications are clinically indicated.

c. Tuberculosis (pulmonary or extra pulmonary) with clinically significant sequelae following treatment, if:

(1) Resistant to treatment; or

(2) The condition is of such severity that the individual is not expected to return to full duty despite appropriate treatment.

d. Severe chronic complications of sexually transmitted diseases including neurosyphilis.

e. Recurrent anaphylaxis, if:

(1) Immunotherapy is not sufficient in reducing the risk;

(2) Avoidance of the trigger results in long-term duty limitations; or

(3) The individual is not expected to return to duty.

f. Chronic, severe, urticarial, or histaminergic angioedema.

g. Hereditary angioedema. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.23.a does not apply.

h. Recurrent rhabdomyolysis, a single episode of idiopathic rhabdomyolysis, or a single episode of rhabdomyolysis that is associated with underlying metabolic or endocrine abnormalities.

i. Severe motion sickness. If due to an underlying disorder, process via the relevant standard. Otherwise, it may require processing through Service specific separation guidance.

j. Sarcoidosis, eosinophilic granuloma, or amyloidosis progressive with severe or multiple organ involvement.

k. Infections (superficial, local, or systemic) that are not responsive to appropriate treatment.

5.24. ENDOCRINE AND METABOLIC CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

a. Adrenal dysfunction, including Addison's disease or Cushing's disease.

b. Diabetes mellitus, unless hemoglobin A1c can be maintained at less than eight percent using only lifestyle modifications (e.g., diet and exercise) or with the following medications (alone or in combination):

(1) Metformin;

(2) Dipeptidyl peptidase 4 inhibitors; or

(3) Glucagon-like peptide-1 receptor agonists.

c. Pituitary dysfunction or mass effect from pituitary tumor.

d. Diabetes insipidus, after treatment and resolution of an underlying etiology.

e. Hyperparathyroidism, when residuals or complications are present.

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

g. Goiter, if mass effect.

h. Persistent, symptomatic, hypothyroidism or hyperthyroidism that is not responsive to therapy.

i. Persistent metabolic bone disease—including, but not limited to, osteoporosis, Paget's disease, and osteomalacia—if:

(1) Associated with pathological fractures; or

(2) The condition prevents the wearing of military equipment.

j. Osteogenesis imperfecta.

k. Hypogonadism with medically required injectable hormone replacement.

l. Hypoglycemia when caused by an insulinoma or other hypoglycemia-inducing tumor.

m. Gout with frequent acute exacerbations or severe bone, joint, or kidney damage.

n. Endocrine hyperfunctioning syndromes including, but not limited to:

(1) Multiple endocrine neoplasia;

(2) Pheochromocytoma;

(3) Salt-wasting congenital adrenal hyperplasia;

(4) Carcinoid syndrome; or

(5) Endocrine tumors of the gastrointestinal tract.

5.25. RHEUMATOLOGIC CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions listed in this paragraph do not meet medical retention standards if the condition requires geographic limitations to protect the individual from infectious disease risk or due to limited monitoring capabilities, is associated with adverse effects from medication, or if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Systemic lupus erythematosus.

b. Mixed connective tissue disease.

c. Progressive systemic sclerosis, including:

(1) Calcinosis;

(2) Raynaud's phenomenon;

(3) Esophageal dysmotility;

(4) Scleroderma; or

(5) Telangiectasia syndrome.

d. Rheumatoid arthritis.

e. Sjögren's syndrome.

f. Chronic autoimmune vasculitides or autoimmune diseases including, but not limited to:

(1) Polyarteritis nodosa.

(2) Behçet's disease.

(3) Takayasu's arteritis.

(4) Giant cell arteritis.

(5) Anti-neutrophil cytoplasmic antibody associated vasculitis.

(6) IgG-4 disease.

(7) Henoch-Schonlein Purpura.

g. Myopathy or polymyositis.

h. Fibromyalgia or myofascial pain syndrome.

i. Connective tissue disorders if associated with cardiac manifestations or limitations from recurrent musculoskeletal dysfunction.

5.26. NEUROLOGIC CONDITIONS.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

b. Cerebrovascular conditions including, but not limited to:

(1) Subarachnoid or intracerebral hemorrhage;

(2) Vascular stenosis;

(3) Stroke;

(4) Aneurysm;

(5) Arteriovenous malformation; or

(6) Recurrent transient ischemic attack unless underlying etiology is identified and definitively treated.

c. Anomalies of the central nervous system or meninges with persistent sequelae including, but not limited to:

(1) Pain.

(2) Significant sensory or motor impairment.

(3) Severe headaches.

(4) Seizures.

(5) Alteration of consciousness, personality, or mental function.

d. Permanent or progressive cognitive impairment due to Alzheimer's disease or other dementias. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.26.a does not apply.

e. Neuromuscular disorders and muscular dystrophy including, but not limited to:

(1) Facioscapulohumeral muscular dystrophy.

(2) Limb girdle dystrophy.

(3) Myotonic dystrophy.

f. Chronic or recurrent demyelinating processes (e.g., multiple sclerosis, transverse myelitis, or recurrent optic myelitis).

g. Migraine, tension, or cluster headaches, when manifested by frequent incapacitating attacks.

h. Traumatic brain injury associated with persistent sequelae including, but not limited to:

(1) Pain.

(2) Significant sensory, cognitive, or motor impairment.

(3) Severe headaches.

(4) Seizures.

(5) Alteration of consciousness, personality, or mental function.

i. Peripheral neuropathy or paralytic disorders resulting in permanent functional impairment.

j. Provoked seizures, if recurrent more than 6 months after the Service member begins treatment and the effects of medication:

(1) Prohibit satisfactory performance of duty;

(2) Require significant follow-up; or

(3) Require modifications to reduce psychological stressors or enhance safety.

k. Epilepsy. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.26.a does not apply.

l. Myasthenia gravis, unless only involving extraocular muscles.

m. Tremor, tic disorders, or dystonia (e.g., Tourette's Syndrome) with significant functional impairment.

n. Recurrent, neurogenic, or unexplained syncope or near syncope that interferes with duty.

5.27. SLEEP DISORDERS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

a. Clinical sleep disorders—including circadian rhythm disorders, insomnia, narcolepsy, cataplexy, or other hypersomnia disorders—that cause sleep disruption resulting in excessive daytime somnolence or other impacts on duty such as:

(1) Mood disturbance;

(2) Irritability; or

(3) Chronic use of prescription medication to promote sleep or maintain daytime wakefulness.

b. Obstructive sleep apnea, of any severity:

(1) With continued symptoms despite treatment with positive airway pressure machines or oral positional devices; or

(2) That requires supplemental oxygen or any chronic medication to maintain wakefulness.

c. Sleep-related movement disorder that causes sleep disruption resulting in excessive daytime somnolence or other impacts on duty, such as:

(1) Mood disturbance;

(2) Irritability; or

(3) Chronic use of prescription medication to promote sleep or maintain daytime wakefulness.

5.28. BEHAVIORAL HEALTH.

The following conditions, defined using the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, unless otherwise stated, are not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis.

a. Schizophrenia, delusional disorder, schizophreniform disorder, schizoaffective disorder, and brief psychotic disorder. Substance- or medication–induced psychotic disorder and psychotic disorder(s) due to another medical condition should be considered on a case-by-case basis.

b. Bipolar I disorder.

c. Other bipolar spectrum disorders—including bipolar II disorder, cyclothymic disorder, substance- or medication–induced bipolar disorder—will be considered on a case-by-case basis if, despite appropriate treatment, they:

(1) Require persistent duty modifications to reduce psychological stressors or enhance safety; or

(2) Impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

d. Other behavioral health conditions, defined using the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders—including, but not limited to, anxiety disorders, depressive disorders, or eating or feeding disorders—will be considered on a case-by-case basis if, despite appropriate treatment, they:

(1) Require persistent duty modifications to reduce psychological stressors or enhance safety; or

(2) Impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

e. Per Paragraph 3.3, disqualifying behavioral health conditions should either be referred to the DES or processed for administrative separation, based on whichever is appropriate for that condition.

5.29. TUMORS AND MALIGNANCIES.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. All malignancies will be evaluated for potential recurrence and need for medical surveillance that could require permanent duty limitations, in accordance with Military Department regulations.

b. Malignant neoplasms that are not responsive to therapy or have residuals of treatment that limit satisfactory performance of duty.

c. Benign tumors with mass effect or that interfere with the wearing of military equipment.

5.30. MISCELLANEOUS CONDITIONS.

Conditions listed in this paragraph do not meet medical retention standards if they require medication for control with frequent monitoring by a medical provider due to potential debilitating or serious side effects or geographic limitations to protect the individual from infectious disease risk.

a. Porphyria.

b. Cold-related disorders or injuries with sequelae.

c. Organ or tissue transplantation for which long-term immunosuppressant therapy is clinically indicated.

d. History of heatstroke or heat injury.

(1) Three or more episodes of heat exhaustion or heat injury within 24 months. A single episode of heat injury with severe complications (e.g., compartment syndrome) that affects successful performance of duty or persistent end organ effects.

(2) Heat stroke, when symptoms fail to resolve or when sequelae pose significant risks for future operations.

e. Any chronic condition that requires immunomodulating or immunosuppressant medications.

f. Any chronic pain condition that requires chronic controlled medications listed under Controlled Substance Schedules 2-4, pursuant to Title 21, United States Code.

g. Chronic complications or effects of surgery that:

(1) Present a significant risk of infection;

(2) Result in duty limitations; or

(3) Require frequent specialty care resulting in an unreasonable requirement on mission execution.

h. Any persistent condition that requires geographic limitations to the member for assignment, temporary duty, or deployment to protect the individual from infectious disease risk, due to limited monitoring capabilities or other reasons.

GLOSSARY

G.1. ACRONYMS.

ACRONYM	MEANING
ASD(HA)	Assistant Secretary of Defense for Health Affairs
DASD(HSP&O)	Deputy Assistant Secretary of Defense for Health Services Policy and Oversight
DASD(MPP)	Deputy Assistant Secretary of Defense for Military Personnel Policy
DES	Disability Evaluation System
DHA	Defense Health Agency
DoDI	DoD instruction
FEV1	forced expiratory volume in one second
MEDPERS	Medical and Personnel Executive Steering Committee
MHS	Military Health System
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USCG	United States Coast Guard
RMSWG	Retention Medical Standards Working Group

G.2. DEFINITIONS.

Unless otherwise noted, these terms and their definitions are for the purpose of this volume.

TERM	DEFINITION
covered personnel	Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load.
garrison conditions	Defined in DoDI 6465.03
heat exhaustion	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 dysfunction (e.g., headache or dizziness).

TERM	DEFINITION
heat injury	Heat exhaustion with clinical evidence of organ or muscle damage without sufficient neurological symptoms to be diagnosed as heat stroke.
heat stroke	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. It can be complicated by organ or tissue damage, systemic inflammatory activation, and disseminated intravascular coagulation.
medical condition	Any disease or residual of an injury that results in a lessening or weakening of the capacity of the body or its parts to perform normally, according to accepted medical principles.
medically required	A medically necessary health care treatment or supply for which there is no medically appropriate substitute that can meet operational requirements.
office, grade, rank, or rating	Defined in DoDI 1332.18.
operational healthcare unit	Defined in DoD Manual 6025.13.
persistent	Twelve months, or less if reasonably anticipated to exceed 12 months.
trial of duty	Service-defined assessment of a Service member's ability to perform the duties of their office, grade, rank, or rating, considering their physical and psychological demands and tasks, medical history, and prognosis.

REFERENCES

Code of Federal Regulations, Title 38, Part 4 (also known as "the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD)")

Commandant Instruction Ml 850.2 (series), "Physical Disability Evaluation System," May 19, 2006

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008

DoD Instruction 1300.28, "Military Service By Transgender Persons And Persons With Gender Dysphoria", September, 4, 2020

DoD Instruction 1332.14, "Enlisted Administrative Separations," January 27, 2014, as amended

DoD Instruction 1332.18, "Disability Evaluation System (DES)," August 5, 2014, as amended

DoD Instruction 1332.30, "Commissioned Officer Administrative Separations," May 11, 2018, as amended

DoD Instruction 1332.45, "Retention Determinations For Non-Deployable Service Members," July 30, 2018

DoD Instruction 5025.01, "DoD Issuances Program," August 1, 2016, as amended

DoD Instruction 6130.03, Volume 1, "Medical Standards for Military Service: Appointment, Enlistment, or Induction" May 5, 2018, as amended

DoD Instruction 6465.03, "Anatomic Gifts and Tissue Donation," June 8, 2016

DoD Instruction 6490.07. "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010

DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013

Kidney Disease: Improving Global Outcomes, "Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease (CKD)," 2012 or current version[1]

Secretary of Defense Memorandum, "Policy Regarding Human Immunodeficiency Virus-Positive Personnel within the Armed Forces," June 6, 2022

United States Code, Title 21

[1] Accessible at https://kdigo.org/guidelines/ckd-evaluation-and-management

Exhibit 5

Communications Plan

U.S. DEPT OF DEFENSE

COMMUNICATION PLAN
POLICY REGARDING HIV-POSITIVE PERSONNEL WITHIN THE ARMED FORCES

Background: There have been significant advances in the diagnosis, prevention, and treatment of human immunodeficiency virus (HIV).

In view of these advances, on June 6, 2022, Secretary Austin signed a memorandum directing updates to Department of Defense (DoD) policies with respect to HIV-positive Service members.

Service members who are identified as HIV-positive, are asymptomatic, and have a clinically confirmed undetectable viral load will not be categorically barred from deploying worldwide or commissioning, nor will they be discharged or separated, solely on the basis of their HIV-positive status.

Such Service members are presumed to be qualified for military service subject to a case-by-case evaluation.

Within 60 days, the Secretaries of the Military Departments and the Commanders of the Combatant Commands will revise their respective regulations, policies, and other guidance consistent with the Secretary's memo.

Appropriate standards for case-by-case evaluations will be developed by a working group convened by the Under Secretary for Personnel and Readiness (USD(P&R)). The USD(P&R) will report the working group's recommendations to the Secretary of Defense within six months.

On a semi-annual basis, beginning six months from the date of the Secretary's memorandum, the Secretaries of the Military Departments will report to the USD(P&R) the number of HIV-positive Service members who have been separated and the number of HIV-positive Service members who are asymptomatic with a clinically confirmed undetectable viral load who have been refused accession.

On June 6 2022 the Department of Justice (DOJ) announced its decision not to seek further review of the decisions in *Harrison* v. *Austin* and *Roe* v. *Austin,* two cases in the U.S. District Court for the Eastern District of Virginia involving challenges to policies adopted by DoD and some of its Components relating to the commissioning and retention of Service members who have tested positive for HIV, but are being treated, are asymptomatic, and have undetectable viral loads. Because the Department of Defense has modified the relevant policies, the Department of Justice has determined an appeal is not warranted. For technical reasons, the Department of Justice filed a notice of appeal on June 6, 2022, which it intends to dismiss on July 6, 2022.

Public Affairs Posture: Active upon public release of the Secretary's memo.

Key Audience:
- Service members
- Congress
- Military and veterans support organizations
- DoD Affinity Groups (includes LGBTQ+ support organizations)
- U.S. public

Topline Messages:
- In view of significant advances in the diagnosis, treatment, and prevention of human immunodeficiency virus (HIV), Secretary Austin has directed updates to the Department's policies with respect to HIV-positive personnel who are serving in the U.S. Armed Forces.
- Under the Department's updated policies, HIV-positive Service members who are asymptomatic and who have a clinically confirmed undetectable viral load will not be categorically barred from commissioning or deploying, nor will they be discharged or separated from military service, solely on the basis of their HIV-positive status.
- The Department's updated guidance is grounded in the latest medical science and follows a series of federal court decisions concluding that the Department of Defense's prior policies were unlawful.

Talking Points:
- The Department of Defense is focused on ensuring the health and readiness of the force.
- As directed in the Secretary's memo, decisions concerning commissioning, deployment, and discharge or separation of Service members who are HIV-positive, asymptomatic, and who have clinically confirmed undetectable viral loads will be made on a case-by-case basis with no restrictions solely on the basis of their HIV-positive status.
- This approach is consistent with the way most DoD Components already handle HIV-positive Service members.
- Just as all Service members must receive required vaccinations to be considered militarily ready, HIV-positive Service members will need to adhere to a treatment regimen that renders them asymptomatic and with a clinically confirmed undetectable viral load to be covered by the Secretary's updated guidance.
- HIV-positive personnel can now take a daily regimen of antiretroviral tablets to achieve and maintain an undetectable viral load.
- The updated DoD policies do not require deployment of all HIV-positive Service members. Instead, the guidance makes clear that HIV-positive Service members who are asymptomatic and who have a clinically confirmed undetectable viral load will be considered on a case-by-case basis.
- The Department's updated guidance applies to current Service members. Enlistment policies remain unchanged.
- The Director of Administration and Management will oversee revision of relevant DoD Instructions cited in the Secretary's memo.
- The policy update follows a series of federal court decisions concluding that DoD's prior policies were unlawful. The U.S. District Court for the Eastern District of Virginia entered permanent injunctions addressing DoD's treatment of asymptomatic HIV-positive individuals

with an undetectable viral load. Because DoD has modified the relevant policies, the Department of Justice has determined than an appeal of those injunctions is not warranted.

Timeline

SD/Front Office	DOJ	OSD Public Affairs	OSD Leg Affairs

Time	Engagement/Media/Event	Principal	OPR	Notes
June 6	SD signs memo	ExecSec	FO	-Memo embargoed according to this plan
June 7	DOJ Hill notifications	DOJ		-DOJ notifies Congressional leadership, Judiciary Committees
June 7	DOD Hill notifications		OSD(LA)	- DOD notifies Defense Committees
June 7	Release SD memo	ExecSec	FO	-Release memo through normal staffing
June 7	Post release, SD memo to defense.gov		OSD(PA)	-Documents posted (link to DoD release) -Embargo lifts
June 7	MSOs/VSOs, DoD Affinity Groups notification		OSD(PA)	-Coincident with public document drop, share documents with MSOs/VSOs, DoD Affinity Groups via email
TBD D+	Follow-on touchpoints with MSOs/VSOs, DoD Affinity Groups		OSD(PA)	Follow-on engagements with groups as necessary; briefers TBD

Policies

Q. What policies are changing?
A. Under the Department's updated policies, HIV-positive Service members who are asymptomatic and who have a clinically confirmed undetectable viral load will not be categorically barred from deploying worldwide or commissioning while they are Service members solely on the basis of their HIV-positive status, nor will they be discharged or separated from military service solely on the basis of their HIV-positive status. Such Service members will instead be evaluated on a case-by-case basis, with appropriate standards for such case-by-case evaluation to be developed by a working group convened by the Under Secretary for Personnel and Readiness.

This approach is consistent with the way most DoD components already handle HIV-positive Service members. The updated guidance allows for case-by-case management across Services and areas of responsibility.

Q. What's changed regarding the diagnosis, prevention, and treatment of HIV?
A. Because of significant advances in the prevention, detection, and treatment of HIV and significant clinical experience with antiretroviral therapy, HIV-positive personnel can now take a daily regimen of antiretroviral tablets to remain asymptomatic and achieve and maintain an undetectable viral load.

Q. How will these new policies affect the readiness of the force?

A. This policy change appropriately balances the readiness of the force while preserving the knowledge, skills, and abilities of covered personnel.

Q. Will other Service members be exposed to greater risk of HIV infection under the new policies?
A. Based on the latest medical science, the Department does not anticipate a significantly increased risk to other Service members. HIV-positive Service members will continue to be prohibited from donating blood. Exposure to blood will be handled in accordance with our standard infectious disease protocols along with post-exposure prophylaxis as needed.

Q. Isn't this policy inconsistent with DoD's policies on COVID-19 vaccination?
A. Our decisions are driven by the medical science in all cases. Just as all Service members must receive required vaccinations to be considered militarily ready, HIV-positive Service members will need to be adhere to a treatment regimen that renders them asymptomatic and with a clinically confirmed undetectable viral load to be covered by the updated guidance. The touchstones in both cases are science and military readiness.

Q. Will HIV-positive individuals be able to enlist?
A. The Department's updated guidance applies to current Service members. Enlistment policies remain unchanged.

Q. Will HIV-positive midshipmen and cadets be able to graduate and commission as officers?
A. The Department's updated guidance applies to all current Service members, including military service academy students. HIV-positive midshipmen and cadets who are asymptomatic and who have a clinically confirmed undetectable viral load will not be categorically barred from commissioning solely on the basis of their HIV-positive status.

Q. Did the White House pressure DoD to change its policies?
A. The Department's updated guidance is grounded in the latest medical science and reflects advances in the diagnosis, prevention, and treatment of HIV. It also follows a series of federal court decisions concluding that DoD's prior policies were unlawful.

Q. Does DoD anticipate any other changes to accession medical policies at this time?
A. The Department recently completed a year-long holistic review of all medical accession standards with appropriate revisions to be published later this year. In light of the updated guidance, the working group will conduct a supplemental review to ensure appropriate standards for case-by-case evaluations of covered personnel are developed and provided to the Secretary of Defense within the next six months.

Public Affairs

Q. How many Service members are currently HIV-positive?
A. As of June 2021 (latest available information), approximately 1,010 HIV-positive individuals were actively serving in the military.

Q. Aren't HIV-positive Service members still at risk of transmitting HIV in combat where Service members often come in contact with blood?

A. Based on the latest medical science, the Department does not believe there is significantly increased risk to other Service members. HIV-positive members will continue to be prohibited from donating blood, and exposure to blood will be handled in accordance with our standard infectious disease protocols along with post exposure prophylaxis as needed.

Q. What were the federal court decisions challenging the Department's prior policies?
A. The two cases are:

Harrison v. *Austin*, No. 18-cv-641 (E.D. Va.)
Roe v. *Austin*, No. 18-cv-1565 (E.D. Va.).

For additional details on these cases, please contact the Department of Justice.

Q. Will an HIV-positive enlisted Service member be able to seek a commission into the Officer Corps?
A. HIV-positive enlisted Service members who are asymptomatic and who have a clinically confirmed undetectable viral load will not be categorically barred from commissioning solely on the basis of their HIV-positive status.

Q. Can current Service members who become infected with HIV continue to serve?
A. Service members who test positive are retained in the service as long as they are able to meet fitness for duty standards.

Q. Are Service members routinely tested for HIV? How often?
A. Yes, Service members are tested at least every two years as well as before and after deployment. Those who test positive are retained in the service as long as they are able to meet fitness for duty standards.

Q. Who will be part of the working group outlined in the Secretary's memo?
A. The members of the working group have not been designated; however, they will include representatives from across the Department.

Q. What will the working group do?
A. The Working Group will develop proposed standards for addressing the changes directed in the Secretary's memo. The Under Secretary for Personnel and Readiness will make recommendations to the Secretary of Defense on appropriate standards for case-by-case evaluations of Service members with HIV as to whether any additional assignment or deployment restrictions should apply within six months from the date of the Secretary's memorandum.

The Working Group may also consider additional matters referred to it by the USD(P&R).

<u>Litigation</u>

Q. Why is the government appealing the injunction?
A. The Department of Justice filed a protective notice of appeal on June 6, 2022, but has stated that it intends to dismiss the appeal on July 6, 2022. For additional details, I refer you to the Solicitor General's letter, which is available on the Department of Justice's website.

Q. Why isn't the government pursuing a full appeal? Did DoD want to appeal?
A. The Department of Defense is updating relevant policies and therefore the Department of Justice determined an appeal is not warranted.

Q. Does DoD think Congress should intervene in the litigation?
A. That is a matter for Congress to determine.

Q. Why is the government litigating so aggressively in the COVID-19 vaccination cases—appealing every adverse decision—but acquiescing to a district court's decision here?
A. The Department of Defense is focused on ensuring the health and readiness of the Force. I refer you to the Department of Justice regarding litigation decisions. Just as all Service members must receive required vaccinations to be considered militarily ready, HIV-positive Service members will need to adhere to a treatment regimen that renders them asymptomatic and with a clinically confirmed undetectable viral load to be covered by the updated guidance. The touchstones in both cases are science and military readiness.

Q. Why is DoD arguing against court orders to deploy Service members who are not vaccinated against COVID-19 as interfering with deference to military decision making, but is not appealing this court order that forces deployment of Service members who are HIV-positive?
A. The updated DoD policies do not require deployment of all HIV-positive Service members. Instead, the guidance makes clear that HIV-positive Service members who are asymptomatic and who have a clinically confirmed undetectable viral load will be considered on a case-by-case basis.

Q. Will DoD continue to litigate other cases challenging its HIV policies (in Maryland, Vermont, etc.)?
A. I refer you to the Department of Justice regarding pending litigation.

Q. Is DoD changing its policies in response to the injunction?
A. The Department of Defense is focused on ensuring the health and readiness of the Force. The updated DoD policies are grounded in the latest medical science and reflect advances in the diagnosis, prevention, and treatment of HIV. The update also follows a series of federal court decisions concluding that DoD's prior policies were unlawful.

Q. Does DoD agree with the courts' conclusion that the prior policies were unlawful?
A. We seek to ensure that all policies are aligned with the latest medical science and the needs of maintaining a healthy, ready, and deployable force.

Q. Will the courts uphold the new policies?
A. The Department's updated policies are grounded in the latest medical science and allow for case-by-case determinations.

Q. How is the district court's [2022] permanent injunction different from its [2019] preliminary injunction?
A. I refer you to the Department of Justice.

Exhibit 6

DoDI 6490.07

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 7

Working Group Memo

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

FEB 10 2023

MEMORANDUM FOR CHAIR, HUMAN IMMUNODEFICIENCY VIRUS WORKING GROUP

SUBJECT: Human Immunodeficiency Virus Working Group Recommendation on Accessions

On June 6, 2022, the Secretary of Defense issued a memorandum, "Policy Regarding Human Immunodeficiency Virus-Positive Personnel within the Armed Forces," which updated the Department of Defense's (DoD) policy with respect to certain, covered personnel who have been identified as Human Immunodeficiency Virus (HIV)-positive. Pursuant to that memorandum, I convened a working group to consider certain matters relating to personnel policy regarding HIV. Among other things, you are considering whether DoD should make any changes to accessions policy for HIV-positive individuals not covered by the Secretary's June 6, 2022 memorandum.

I hereby direct the working group to provide a recommendation to me concerning whether to amend DoD's accession policy, as it pertains to HIV-positive individuals seeking to join the military, no later than April 1, 2023.

Gilbert R. Cisneros, Jr.

Exhibit 8

AJ Waiver Denials

MOD 16 TAB C

CENTCOM Medical Waiver Request

Patient Name (Last, First): REDACTED DOB: REDACTED SSN(Last 4): REDACTED

Previous Deployments: 0 Destination (country): Kuwait Diagnosis (Lay term): DL7; ICD10: B20

Age: 29 Sex: M Grade: SGT/E5 Service: ARNG Home Station: REDACTED

Years of Service: UNK Active/Reserve/Guard/Civilian: ARNG MOS/Job Description: REDACTED

Deployment Length: 12 months Previous Waivers (Y/N): N Currently Deployed (Y/N): N

Waiver POC Name/E-mail/Phone: REDACTED, COL, SP, REDACTED

Case Summary (To be completed by provider, including clinical information necessary to make a disposition. See most recent updated MOD 16 and accompanying MOD 16-TAB A for required information. Attach supporting medical documentation (Lack of necessary supporting documentation will result in disapproval):

SGT REDACTED has ICD10: B20 diagnosis with DL7 profile requirements. Attached are two years of office notes and labs. Attached is recent lab dated 20221004. Current medication Genvoya tab 1PO QD., Atorvastatin 10mg QD. SGT REDACTED has never been hospitalized for this diagnosis. Thank you for your review.

I have reviewed the case summary and hereby submit this request.

Signature: REDACTED Digitally signed by REDACTED Date: 2022.12.03 13:18:54 -05'00'

Commander Approval: REDACTED Digitally signed by REDACTED Date: 2022.12.03 13:41:58 -05'00'

CENTCOM Surgeon / Component Surgeon Response

Waiver Approval: ☐ **YES** ☑ **NO**

Signature: CHENAULT.JANET.CAROL.1046691055 Digitally signed by CHENAULT.JANET.CAROL.1046691055 Date: 2022.12.05 07:32:28 -05'00' **Date:** 05DEC2022

CENTCOM Command Surgeon

NOT APPROVED

Comments:

The country of Kuwait does not allow individuals with this diagnosis to enter/stay in the country of Kuwait. According to Department of State travel guidance at https://travel.state.gov, "Some HIV/AIDS entry restrictions exist for visitors to and foreign residents of Kuwait. Residency permits require an HIV/AIDS test and permits may be denied if applicants test positive. If HIV-related illness becomes known, the resident must leave the country or be deported."

For Official Use Only: This document may contain information exempt from mandatory disclosure under the Freedom of Information Act (FOIA) of 1986 {Public Law 99-570, 5 USC 552(B)}. This information is also protected by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 {Public Law 104-191} and any implementing regulations. It must be safeguarded from any potential unauthorized disclosure. If you are not the intended recipient, please contact the sender by reply e-mail and permanently delete/destroy all copies of the original message. Unauthorized possession and/or disclosure of protected health information may result in personal liability for civil and federal criminal penalties.

MOD 16 TAB C

CENTCOM Medical Waiver Request

Patient Name (Last, First): REDACTED DOB: REDACTED SSN(Last 4): REDACTED

Previous Deployments: 0 Destination (country): Kuwait Diagnosis (Lay term): DL7; ICD10: B20

Age: 29 Sex: M Grade: SGT/E5 Service: ARNG Home Station: REDACTED

Years of Service: UNK Active/Reserve/Guard/Civilian: ARNG MOS/Job Description: 25Q

Deployment Length: 12 month Previous Waivers (Y/N): N Currently Deployed (Y/N): N

Waiver POC Name/E-mail/Phone: REDACTED, COL, SP, REDACTED

Case Summary (To be completed by provider, including clinical information necessary to make a disposition. See most recent updated MOD 16 and accompanying MOD 16-TAB A for required information. Attach supporting medical documentation (Lack of necessary supporting documentation will result in disapproval):

SGT REDACTED has ICD10: B20 diagnosis with DL7 profile requirements. Attached are two years of office notes and labs. Attached is recent lab dated 20221004. Current medication Genvoya tab 1PO QD., Atorvastatin 10mg QD. SGT REDACTED has never been hospitalized for this diagnosis. Thank you for your review.

I have reviewed the case summary and hereby submit this request.

Signature:_____ **Commander Approval:**_____

CENTCOM Surgeon / Component Surgeon Response

Waiver Approval: ☐ **YES** ☑ **NO**

Signature: HALL.ANDREW.B.1140477571 Digitally signed by HALL.ANDREW.B.1140477571 Date: 2022.12.05 10:59:20 -05'00' **Date:** 5 Dec 2022

CENTCOM Command Surgeon

NOT APPROVED

Comments:

Meets USCENTCOM entry requirements for HIV, but Kuwait restricts those with HIV from entering the country. Per the US State Department on Kuwait: Some HIV/AIDS entry restrictions exist for visitors to and foreign residents of Kuwait. Residency permits require an HIV/AIDS test and permits may be denied if applicants test positive. If HIV-related illness becomes known, the resident must leave the country or be deported.

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Exhibit 9

AJ Waiver Approved

MOD 16 TAB C

CENTCOM Medical Waiver Request

Patient Name (Last, First): REDACTED DOB: REDACTED SSN(Last 4): REDACTED

Previous Deployments: 0 Destination (country): Saudi Arabia Diagnosis (Lay term): DL7; ICD10: B20

Age: 29 Sex: M Grade: E5 Service: ARNG Home Station: REDACTED

Years of Service: UNK Active/Reserve/Guard/Civilian: ARNG MOS/Job Description: REDACTED

Deployment Length: 9 months Previous Waivers (Y/N): N Currently Deployed (Y/N): N

Waiver POC Name/E-mail/Phone: COL REDACTED, SP, REDACTED

Case Summary (To be completed by provider, including clinical information necessary to make a disposition. See most recent updated MOD 16 and accompanying MOD 16-TAB A for required information. Attach supporting medical documentation (Lack of necessary supporting documentation will result in disapproval):

SGT REDACTED has ICD10: B20 diagnosis with DL7 profile requirements. His is scheduled for deployment to REDACTED Airbase with mobilization to MFGI at FT. Hood, TX, Kuwait for in-processing less than 14 days with final destination REDACTED Airbase. Level 1 medical treatment provided by 1-182nd IN BN, Role 2 with 378th EDMS located at REDACTED Airbase and REDACTED Military Medical City for referrals on case by case bases. Attached are two years of office notes and labs. Attached is recent lab dated 20221004. Current medication Genvoya tab 1PO QD., Atorvastatin 10mg QD. SGT REDACTED has never been hospitalized for this diagnosis.

20230111-FT. Hood MOB BDE states they can deploy SGT REDACTED direct to Saudi Arabia without transition through Kuwait. I respectfully request second review of this waiver. Thank you, COL REDACTED

I have reviewed the case summary and hereby submit this request.

Signature: REDACTED Digitally signed by REDACTED Date: 2022.12.27 15:42:59 -05'00' **Commander Approval:** REDACTED Digitally signed by REDACTED Date: 2022.12.27 16:04:58 -05'00'

CENTCOM Surgeon / Component Surgeon Response

Waiver Approval: ☑ **YES** ☐ **NO**

Signature: CHENAULT.JANET.CAROL.1046691055 Digitally signed by CHENAULT.JANET.CAROL.1046691055 Date: 2023.01.11 13:39:44 -05'00' **Date:** 11JAN2023

REDACTED, Surgeon

APPROVED

By COL Janet C. Chenault at 1:39 pm, Jan 11, 2023

Comments:

SM meets guidelines for deployment with HIV and non-detectable viral load.
According to State Department: Saudi Arabia has not imposed HIV/AIDS or hepatitis travel restrictions on other categories of travelers. Please inquire directly with the Embassy of Saudi Arabia before you travel.

For Official Use Only: This document may contain information exempt from mandatory disclosure under the Freedom of Information Act (FOIA) of 1986 {Public Law 99-570, 5 USC 552(B)}. This information is also protected by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 {Public Law 104-191} and any implementing regulations. It must be safeguarded from any potential unauthorized disclosure. If you are not the intended recipient, please contact the sender by reply e-mail and permanently delete/destroy all copies of the original message. Unauthorized possession and/or disclosure of protected health information may result in personal liability for civil and federal criminal penalties.

Exhibit 10

AJ ETP

Peter Perkowski

From: [redacted]@gmail.com
Sent: Monday, February 6, 2023 11:27 AM
To: Peter Perkowski
Subject: Fwd: SGT [redacted] (Saudi Arabia Deployment)
Attachments: ETP G1 Guidance 24 Mar 2021.pdf; Untitled attachment 00314.htm; Policy Regarding Human Immunodeficiency Virus-Positive Personnel within the Armed Forces OSD004582-22 (002).pdf; Untitled attachment 00317.htm

Thanks in Advance,
[redacted]

Begin forwarded message:

From: [redacted]@gmail.com
Date: February 6, 2023 at 12:23:19 MST
To: SFC [redacted] <[redacted]>
Subject: Fwd: SGT C (Saudi Arabia Deployment)

Thanks in Advance,
[redacted]

Begin forwarded message:

From: "Rossdeutscher, Karl W CPT USARMY 157 INF BDE (USA)" [redacted]@army.mil>
Date: February 6, 2023 at 11:42:59 MST
To: [redacted]@gmail.com, [redacted] COL USARMY NG [redacted] ARNG (USA)" [redacted]@army.mil>
Cc: "Staples, Anysia N (Ann) SSG USARMY USAR LEGAL CMD (USA)" [redacted]@army.mil>
Subject: FW: SGT [redacted] (Saudi Arabia Deployment)

Greetings,

This is the information I received.

The person requesting is MAJ Staples from HQDA G1 office.

v/r,
KARL W. ROSSDEUTSCHER

CPT/ 42B
CRC ARCENT LNO
Joint Individual Augmentation Division (JIAD)
Building 1013
Fort Bliss, TX
REDACTED @ARMY.MIL
CELL: REDACTED
OFFICE: REDACTED

From: Staples, Serena Karin MAJ USARMY HQDA DCS G-1 (USA) REDACTED @army.mil>
Sent: Monday, February 6, 2023 11:16 AM
To: Rossdeutscher, Karl W CPT USARMY 157 INF BDE (USA) REDACTED @army.mil>; Adams, Robert C Jr MAJ USARMY 103 ESC (USA) REDACTED @army.mil>; Brown, Katrina N SFC USARMY USARCENT (USA) REDACTED @army.mil>; Gause, Robert L CIV USARMY USARCENT (USA) REDACTED @mail.mil>
Cc: Frye, Joseph A SSG USARMY 85 SPT CMD (USA) REDACTED @army.mil>; Villegas, Gregorio R SGT USARMY (USA) REDACTED @army.mil>; REDACTED COL USARMY NG REDACTED (USA) REDACTED @army.mil>; Edwards, Johanna L CIV NG NGB (USA) REDACTED @army.mil>; Shult, Carrie E CIV USARMY HQDA DCS G-1 (USA) REDACTED @army.mil>; Shult, Carrie E CIV USARMY HQDA DCS G-1 (USA) REDACTED @army.mil>; Myers, Spencer C CIV USARMY HQDA DCS G-1 (USA) REDACTED @army.mil>
Subject: RE: SGT RE (Saudi Arabia Deployment)

Good Afternoon,

In addition to the ARCENT Medical Waiver, the Soldier will need to submit an ETP packet up to HQDA for any OCONUS deployment or ADOS orders over 30 days for approval. The packet will go through OTSG, OTJAG, and ASA MR&A for review and final approvals. This is to ensure the Soldier has the resources needed to fulfill his/her deployment.

The June 6th memo put out guidance for Soldiers with certain medical conditions can be deployable. But, until clarification guidance is approved, a Soldier must still complete the ETP packet with the Combatant Command's medical waiver in order to be considered for a deployment.

I attached the requirements to submit an ETP. Once documents are complete, the Soldier can send directly to me for processing.

V/r,

MAJ Staples

Serena K. Staples MPH, MSHS, RN, BSN, CPH
MAJ/AN

Health Promotion and Policy Officer
Army Resilience Directorate (ARD)
HQDA, Deputy Chief of Staff- G1 - Pentagon
Army 365 E-mail: REDACTED
Personal Cell: REDACTED

From: Rossdeutscher, Karl W CPT USARMY 157 INF BDE (USA) REDACTED @army.mil>
Sent: Monday, February 6, 2023 12:54 PM
To: Adams, Robert C Jr MAJ USARMY 103 ESC (USA) REDACTED @army.mil>; Brown, Katrina N SFC USARMY USARCENT (USA) REDACTED @army.mil>; Gause, Robert L CIV USARMY USARCENT (USA) REDACTED @mail.mil>
Cc: Frye, Joseph A SSG USARMY 85 SPT CMD (USA) REDACTED @army.mil>; Villegas, Gregorio R SGT USARMY (USA) REDACTED @army.mil>; Bulwinkle, Marion A III COL USARMY NG REDACTED (USA) REDACTED @army.mil>; Staples, Serena Karin MAJ USARMY HQDA DCS G-1 (USA) REDACTED @army.mil>
Subject: RE: SGT REDACTED

Greetings,

From my understanding, the R E ARNG submitted a waiver for the SM to mobilize to ARCENT AOR, but the waiver could only be approved if travel was figured out. The R E ARNG's COL REDACTED (State G3) spoke with Mr Shaw to see if it was possible to proceed this way. It was determined that it was possible, so R E ARNG sent the SM to CRC for further processing. The waiver was approved based on the agreement the SGT REDACTED could fly direct into Saudi Arabia. I spoke with Mr Shaw who referred me to you to get the LOA. I have not submitted a travel packet because ARCENT does not normally use COMAIR as a means of travel as the funding goes to the SAAMs flight.

I am awaiting a response from G33 Mobility to confirm there is no COMAIR LOA.

v/r,
KARL W. ROSSDEUTSCHER
CPT/ 42B
CRC ARCENT LNO
Joint Individual Augmentation Division (JIAD)
Building 1013
Fort Bliss, TX
REDACTED @ARMY.MIL
CELL: REDACTED
OFFICE: REDACTED

From: Adams, Robert C Jr MAJ USARMY 103 ESC (USA) REDACTED @army.mil>
Sent: Monday, February 6, 2023 10:40 AM
To: Rossdeutscher, Karl W CPT USARMY 157 INF BDE (USA)

REDACTED @army.mil>; Brown, Katrina N SFC USARMY USARCENT (USA) REDACTED @army.mil>; Gause, Robert L CIV USARMY USARCENT (USA) REDACTED @mail.mil>
Cc: Frye, Joseph A SSG USARMY 85 SPT CMD (USA) REDACTED @army.mil>; Villegas, Gregorio R SGT USARMY (USA) REDACTED @army.mil>; REDACTED REDACTED COL USARMY NG REDACTED (USA) REDACTED @army.mil>; Staples, Serena Karin MAJ USARMY HQDA DCS G-1 (USA) REDACTED @army.mil>
Subject: RE: SGT REDACTED

ALCON,

I am on a call with HQDA. Do you know if a packet was put submitted for him to travel? Who cleared him to go OCONUS?

//////////////////BREAK////////////////

MAJ Staples,

CPT Rossdeutscher is the SM I have been communicating with.

V/R

MAJ Robert C. Adams, Jr.
Ft. Bliss Mobilization Division, S-1
Office: REDACTED
GC: REDACTED

Create Viscious Harmony – GEN Mattis

From: Rossdeutscher, Karl W CPT USARMY 157 INF BDE (USA) REDACTED @army.mil>
Sent: Monday, February 6, 2023 9:57 AM
To: Brown, Katrina N SFC USARMY USARCENT (USA) REDACTED @army.mil>; Gause, Robert L CIV USARMY USARCENT (USA) REDACTED @mail.mil>
Cc: Frye, Joseph A SSG USARMY 85 SPT CMD (USA) REDACTED @army.mil>; Villegas, Gregorio R SGT USARMY (USA) REDACTED @army.mil>; Adams, Robert C Jr MAJ USARMY 103 ESC (USA) REDACTED @army.mil>; REDACTED REDACTED COL USARMY NG REDACTED (USA) REDACTED @army.mil>
Subject: Fw: SGT REDACTED

G33 Mobility,

Good morning. We are looking into getting an LOA for SGT REDACTED to fly direct into Saudi Arabia. The SM is not authorized to traverse through Qatar nor Kuwait due to medical restriction. MAJ Adams stated it is up to ARCENT to provide the LOA. From past conversations, I did not think we did this due to the expense of the SAAMs flight; however, due to this circumstance I wanted to double check.

Please reach out if you have any questions regarding this matter.

v/r,

KARL W. ROSSDEUTSCHER

CPT/ 42B
CRC ARCENT LNO
Joint Individual Augmentation Division (JIAD)
Building 1013
Fort Bliss, TX
REDACTED @ARMY.MIL
CELL: REDACTED

OFFICE: REDACTED

From: Adams, Robert C Jr MAJ USARMY 103 ESC (USA) REDACTED @army.mil>
Sent: Friday, February 3, 2023 3:37 PM
To: Rossdeutscher, Karl W CPT USARMY 157 INF BDE (USA) REDACTED @army.mil>
Cc: Frye, Joseph A SSG USARMY 85 SPT CMD (USA) REDACTED @army.mil>; Villegas, Gregorio R SGT USARMY (USA) REDACTED @army.mil>; USARMY Ft Bliss IMCOM Central MESG DoMad S-1 CRC <usarmy.bliss.imcom-central.mesg.domad-s-1-crc@army.mil>
Subject: RE: SGT REDACTED

ALCON,

I just spoke with 1A Mob and was informed that a COMAIR request needs to be sent to ARCENT for approval. They will be the ones responsible for funding the flight.

I am attaching a COMAIR request memo. This memo is for EUCOM but I am sure with a few changes it should work for ARCENT as well.

V/R

MAJ Robert C. Adams, Jr.
Ft. Bliss Mobilization Division, S-1
Office: REDACTED
GC: REDACTED

Create Viscious Harmony – GEN Mattis

From: Rossdeutscher, Karl W CPT USARMY 157 INF BDE (USA) REDACTED l@army.mil>
Sent: Thursday, February 2, 2023 10:42 AM
To: Adams, Robert C Jr MAJ USARMY 103 ESC (USA) REDACTED @army.mil>
Cc: Frye, Joseph A SSG USARMY 85 SPT CMD (USA) REDACTED @army.mil>;

Villegas, Gregorio R SGT USARMY (USA) [REDACTED]@army.mil>
Subject: SGT [REDACTED]

Maj Adams,

We spoke today regarding SGT [REDACTED]'s travel direct into KSA. Due to medical restrictions, the SM is not able to fly through Qatar nor Kuwait. I have attached a copy of his TCS orders.

The TCS orders does not have an LOA on it for travel into theater. We tried doing a DTS yesterday but was told by the people assisting that the order does not authorize commercial travel.

The SM's official passport # is [REDACTED]

If you need anything regarding this action, please let me know.

v/r,
KARL W. ROSSDEUTSCHER
CPT/ 42B
CRC ARCENT LNO
Joint Individual Augmentation Division (JIAD)
Building 1013
Fort Bliss, TX
[REDACTED]@ARMY.MIL
CELL: [REDACTED]
OFFICE: [REDACTED]

Exhibit 11

CJ Email

Peter Perkowski

Subject: FW: [URL Verdict: Neutral][Non-DoD Source] Fwd: DoD Memorandum

Begin forwarded message:

From: "Peterson, Ryan L LCDR USN NSA MID SOUTH MIL TN (USA)" <REDACTED>
Date: November 15, 2022 at 7:46:01 AM PST
To: REDACTED
Subject: RE: [URL Verdict: Neutral][Non-DoD Source] Fwd: DoD Memorandum

Good Morning DC2,

Thank you for the email. I'm happy to talk to the Liason. I'll look forward to his call.

I am aware of the Memo. There is a working group currently working on what the updated instruction will look like, and how it will read. As things are now yes, you are deployable. But currently per MILPERSMAN 1300-1300 that is limited platforms with a fulltime medical officer assigned to it. For example, you can't go to a ship with an IDC as the sole provider because of their level of training. We'll see if that changes when the new instruction is released. On top of that there is still the country restrictions that is also touched upon in the MILPERSMAN.

R/
LCDR Peterson

From: REDACTED <REDACTED>
Sent: Monday, November 14, 2022 5:10 PM
To: Peterson, Ryan L LCDR USN NSA MID SOUTH MIL TN (USA) <REDACTED>
Subject: [URL Verdict: Neutral][Non-DoD Source] Fwd: DoD Memorandum

Sir,

Please see below.

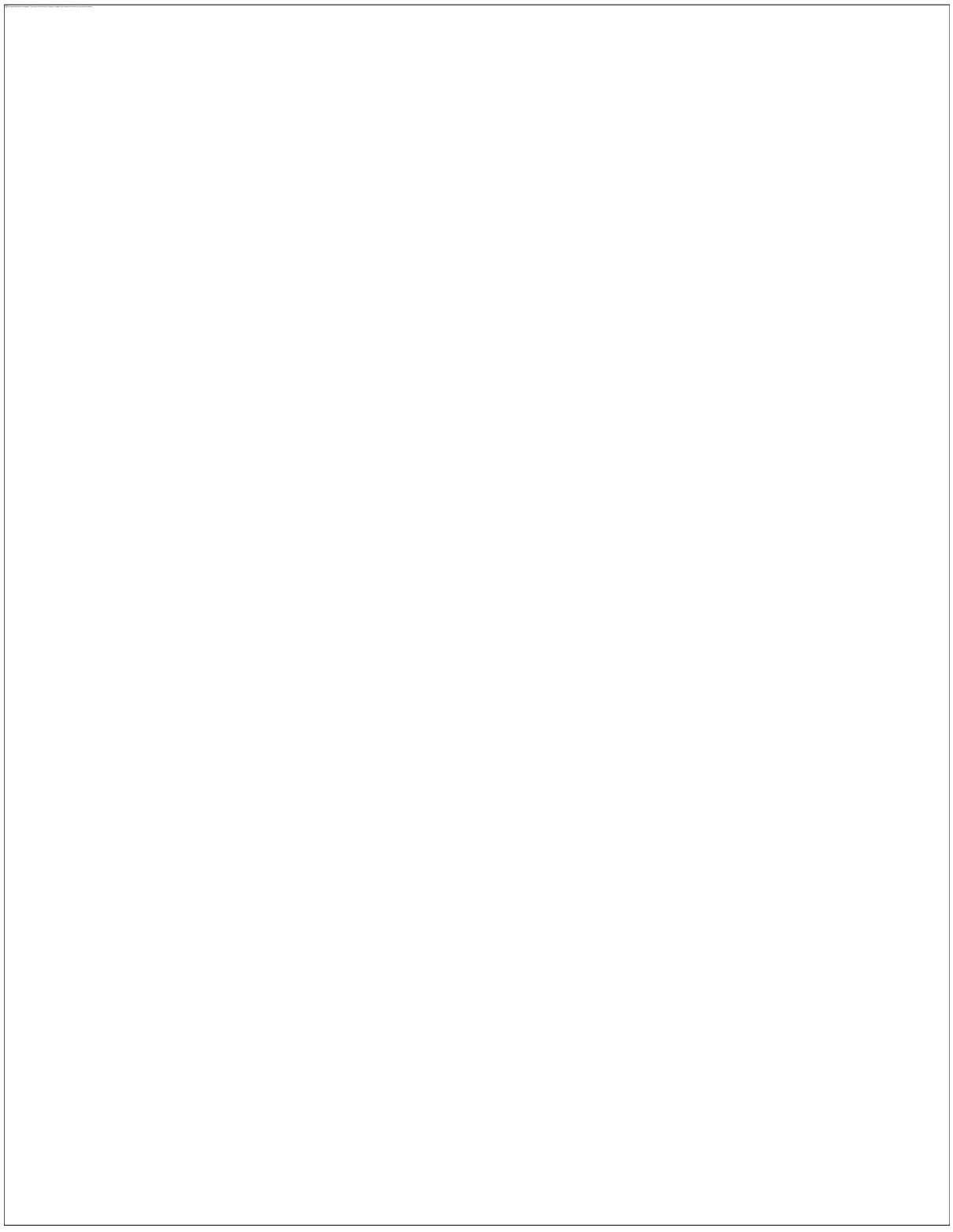
REDACTED
Cell REDACTED

Begin forwarded message:

From: REDACTED <REDACTED>
Date: November 14, 2022 at 2:36:08 PM PST
To: ryan.l.peterson REDACTED
Subject: DoD Memorandum

Good Evening Sir,

I will be having a phone call scheduled for the 18th if that ok with you? Kevin O'brian will be talking on my behalf. He is the liaison for people in my situation at Balboa Naval Hospital. I've also attached a memorandum stating we are deployable as long as we are undetectable. Which I have been since finding out my statues. Thank you for your time.



POLICY-REGARDING-HUMAN-IMMUNODEFICIENCY-VIRUS-POSITIVE-PERSONNEL-WITHIN-THE-ARMED-FORCES
PDF Document · 608 KB

REDACTED
Cell REDACTED

Exhibit 12

CJ Email 2

Peter Perkowski

From: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>
Sent: Tuesday, January 17, 2023 12:45 PM
To: peter@perkowskilegal.com; 'Harding, John'; 'Bauer, Julie'; 'Gailey, Lauren'; sommera@gtlaw.com; 'Scott Schoettes'; 'Kara Ingelhart'; 'Greg Nevins'
Cc: Berman, Keri L. (CIV); Barghaan, Dennis (USAVAE)
Subject: REDACTED

Counsel,

Following up on Petty Officer REDACTED we understand he has been assigned his next orders, which are to New London, Connecticut. However, if your client still wishes to be considered for the courier position based in Italy, the Navy would send a waiver request to CENTCOM given the requirements of the position. If your client would like to proceed in that way, he should reach out to his detailer to ask that a waiver request be sent to CENTCOM related to the courier position he requested. We can make no representation as to how CENTCOM would adjudicate that waiver request.

Regards,
Josh

Joshua C. Abbuhl
Trial Attorney
United States Department of Justice
Civil Division – Federal Programs Branch
1100 L Street NW
Washington, DC 20005
(202) 616-8366 | joshua.abbuhl@usdoj.gov

Exhibit 13

EJ Email

Peter Perkowski

Subject: FW: HIV Program changes (UNCLASSIFIED)

From: REDACTED <REDACTED>
Sent: Monday, August 1, 2022 1:18 PM
To: REDACTED <REDACTED>
Subject: Fwd: HIV Program changes (UNCLASSIFIED)

From: "USARMY Ft Knox HRC Mailbox EPMD Special Actions Branch" <usarmy.knox.hrc.mbx.epmd-special-actions-branch@army.mil>
Date: Monday, August 1, 2022 at 7:02:27 PM
To: "REDACTED" <REDACTED>
Cc: "Cox, Michael CIV USARMY HRC (USA)" <REDACTED>
Subject: RE: HIV Program changes (UNCLASSIFIED)

Good afternoon,

1SG HIV Soldier are not deployable. We reassign to MOTE unit at BDE or higher because the units typically do not deploy as a whole, but as a slice. Therefore that SM would be and could be moved to another unit not in a deployment cycle. Soldiers cannot be reassigned OCONUS except to Alaska or Hawaii, due to SOFA agreement. Currently the only way a Soldier can go OCONUS is as an approved ETP by MEDCOM. I hope this clarifies a little better.

Thank you
v/r
George Cote Jr.
Compassionate/Soldier Actions QC
Human Resources Command
Special Actions Branch, OMD
Fort Knox, KY 40121
DSN: REDACTED
COM: REDACTED
GOV CELL: REDACTED

If replying or inquiring about your case status or adjudication please do not email me directly. You can contact me directly by either my GOV cell, number provided above or reply back directly to this email or send an email to one of our team boxes provided below. Pleased include ATTN: Mr. Cote in the subject line.

Effective immediately, Compassionate Action and Soldier Actions will be forwarded to:
usarmy.knox.hrc.mbx.epmd-compassionate-section@army.mil

usarmy.knox.hrc.mbx.epmd-special-actions-branch@army.mil

Health Insurance Portability and Accountability Act: This document may contain confidential information that is legally privileged under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL 04-191) and its various implementing regulations. If this correspondence contains healthcare information it is being provided to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You are obligated to maintain it in a safe, secure and confidential manner. Unauthorized re-disclosure or failure to maintain confidentiality subjects you to application of appropriate civil and federal criminal sanctions. If you have received this correspondence in error, destroy any copies you have made and notify the sender.

You may find our functional email address in Microsoft Outlook, Global Address List, under the name HRC EPMD Family Travel Section or HRC EPMD MED COORD TEAM Our new mailing address is:
U.S. ARMY HUMAN RESOURCES COMMAND
ATTN:AHRC-EPO-A
1600 SPEARHEAD DIVSION AVE, DEPT # 334
FORT KNOX, KY 40122-5303
You may reach our section by telephone at (502) 613-5860. Any concerns or questions may be directed to the provided email account or telephone number.

-----Original Message-----
From: REDACTED <REDACTED>

Sent: Monday, August 1, 2022 12:08 PM
To: USARMY Ft Knox HRC Mailbox EPMD Special Actions Branch <usarmy.knox.hrc.mbx.epmd-special-actions-branch@army.mil>
Cc: Cox, Michael CIV USARMY HRC (USA) <REDACTED>
Subject: RE: HIV Program changes (UNCLASSIFIED)

CLASSIFICATION: UNCLASSIFIED

Mr. Cote,

Well nice to meet you. My big question is can we be assigned to a MTOE unit in the states and it be up to the medical team on whether or not we can deploy? If I understand you correctly, we can as long as it is a BDE level

billet or higher? Thank you for the information!

Respectfully,
REDACTED
1SG, USA
REDACTED
Gov Cell: REDACTED
(Signal App) REDACTED

-----Original Message-----
From: USARMY Ft Knox HRC Mailbox EPMD Special Actions Branch <usarmy.knox.hrc.mbx.epmd-special-actions-branch@army.mil>
Sent: Monday, August 1, 2022 5:59 PM
To: REDACTED <REDACTED>
Cc: Cox, Michael CIV USARMY HRC (USA) <REDACTED>
Subject: RE: HIV Program changes (UNCLASSIFIED)
Importance: High

Good morning,

1SG first myself and Mr. Cox are the HIV managers here at HRC. The general rules (the Regulation) we follow are below. Unfortunately to the best of my knowledge the memo doesn't change our current practices.

1. Assign to CONUS, AK, HI only.
2. No OCONUS (SOFA agreements and pain/ political factors)
3. Assign to TDA when possible. Some MOS are only authorized in MTOE units. We assign to MTOE at the BDE level or higher as commanders determine "who" they are going to deploy.
4. The attached memo will not affect how we assign that population.

Thank you
v/r
George Cote Jr.
Compassionate/Soldier Actions QC
Human Resources Command
Special Actions Branch, OMD
Fort Knox, KY 40121
DSN: REDACTED
COM: REDACTED
GOV CELL: REDACTED

If replying or inquiring about your case status or adjudication please do not email me directly. You can contact me directly by either my GOV cell,

number provided above or reply back directly to this email or send an email to one of our team boxes provided below. Pleased include ATTN: Mr. Cote in the subject line.

Effective immediately, Compassionate Action and Soldier Actions will be forwarded to:
usarmy.knox.hrc.mbx.epmd-compassionate-section@army.mil

usarmy.knox.hrc.mbx.epmd-special-actions-branch@army.mil

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You may find our functional email address in Microsoft Outlook, Global Address List, under the name HRC EPMD Family Travel Section or HRC EPMD MED COORD TEAM Our new mailing address is:
U.S. ARMY HUMAN RESOURCES COMMAND
ATTN:AHRC-EPO-A
1600 SPEARHEAD DIVSION AVE, DEPT # 334
FORT KNOX, KY 40122-5303
You may reach our section by telephone at (502) 613-5860. Any concerns or questions may be directed to the provided email account or telephone number.

-----Original Message-----
From: REDACTED <REDACTED>

Sent: Sunday, July 31, 2022 11:42 AM
To: USARMY Ft Knox HRC Mailbox EPMD Special Actions Branch <usarmy.knox.hrc.mbx.epmd-special-actions-branch@army.mil>
Subject: HIV Program changes (UNCLASSIFIED)

CLASSIFICATION: UNCLASSIFIED

ALCON,

I would like to ask for the point of contact information for the new EPMD

HIV Manager housed within the Special Actions Branch? I know Mrs. Rhyls Michaels (I probably spelt her name wrong) was doing it before but I am told she is no longer there so I would like to contact the new person. More specifically, I am curious with the new update to the HIV policy (attached), are Soldiers now allowed to be slotted in MTOE positions? Any additional information you can provide, especially the new manager's information, would be greatly appreciated.

Respectfully,
REDACTED
1SG, USA
REDACTED
Gov Cell: REDACTED
(Signal App) REDACTED

CLASSIFICATION: UNCLASSIFIED

CLASSIFICATION: UNCLASSIFIED

Exhibit 14

DJ Email

Peter Perkowski

From: REDACTED <REDACTED>
Sent: Sunday, April 2, 2023 6:34 AM
To: peter@perkowskilegal.com
Subject: FW: Changes to HIV program with DOD Directive

-----Original Message-----
From: Shult, Carrie E CIV USARMY HQDA DCS G-1 (USA)
<REDACTED>
Sent: Thursday, July 21, 2022 12:34 PM
To: REDACTED
<REDACTED>; Myers, Spencer C CIV USARMY HQDA DCS G-1
(USA) <REDACTED>
Subject: RE: Changes to HIV program with DOD Directive

Hello SFC RED ACT,

Thanks for your email. The Army is participating in a DoD WG to address the issues highlighted in the memo.

For your ETP request, we are happy to support any questions you have and highly recommend you submit as early as possible if you intend to apply. I understand the confidentiality and privacy concerns, but I would ask for you to inquire (as generally as you can) if you can apply without having the ETP. I have heard of programs that will do the ETP once you have been accepted into the program.

Let me know if you have any questions.

R,

Carrie Shult
Ready and Resilient Integration Program Manager

DCS, G1 Army Resilience Directorate

Teleworking cell: REDACTED
O365: REDACTED

-----Original Message-----
From: REDACTED
<REDACTED>
Sent: Tuesday, July 19, 2022 12:21 PM
To: Myers, Spencer C CIV USARMY HQDA DCS G-1 (USA)
<REDACTED>; Shult, Carrie E CIV USARMY HQDA DCS G-1
(USA) <REDACTED>
Subject: Changes to HIV program with DOD Directive
Importance: High

Good Morning,
I was wondering how the Attached DOD Directive changes the policy outlined In AR 600-110 for accessions physicals and the exception to policy process? I will be applying to the Enlisted to medical degree program through USUHS and wanted to ensure that there is no issue as I proceed through this process. My HIV Program Manager didn't know and suggested I do an ETP however the ETP timeline will not work with the application timeline as the application must be submitted by 30 September 2022 with a conditional release from my branch. Any assistance would be greatly appreciated. Have a great day.

Very Respectfully,

REDACTED
SFC, REDACTED
REDACTED
Government Cell: REDACTED
Personal Cell: REDACTED

REDACTED

Exhibit 15

July 1 Letter

WINSTON & STRAWN LLP

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JOHN W. H. HARDING
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July 1, 2022

VIA ELECTRONIC MAIL

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Dennis Barghaan
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Eastern District of Virginia
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Dennis.Barghaan@usdoj.gov

Re: *Harrison et al. v. Austin.*, 1:18-cv-641; *Roe et al. v. Austin*, 1:18-cv-1565

Dear Josh:

During our June 24 call regarding expediting relief for Sergeant Harrison, Scott mentioned that Plaintiffs had concerns regarding the Department of Defense's compliance with the permanent injunction issued by the Court in the above captioned matters. In addition, he advised that Plaintiffs had a few suggested modifications to the relevant regulations that would help clarify the standard for the deployment and commissioning of Service members living with HIV and ensure a smooth transition to the full service of such individuals.

In response to your request for specifics regarding Plaintiffs' concerns—and in the spirit of cooperation toward achieving the Secretary Austin's recently announced goal of bringing the standards in line with the contemporary medical understanding of HIV—Plaintiffs make the following requests, the first four of which must be undertaken to bring the DOD into compliance with the Court's injunction.

1. **Revise DODI 6130.03 to include the relevant medical standards for commissioning as a Service member living with HIV and to eliminate the precatory language regarding evaluation on a "case-by-case" basis.**

For other medical conditions listed in DODI 6130.03, any specific medical criteria are described explicitly in Section 5 and do not require cross-reference to another section of the Instruction. *See*, *e.g.*, Section 5.2, Head, (b) ("Loss, or absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving any residual defect in excess of 1 square inch (6.45 square centimeters),

or the size of a U.S. quarter coin."); Section 5.3, Eyes, (b) Conjunctiva (2) ("Current pterygium if condition encroaches on the cornea in excess of 3 millimeters (mm), is symptomatic, interferes with vision, or is progressive."). HIV should be handled in the same fashion as other listed medical conditions.[1] The EDVA opinion and order made clear that only people living with HIV who have a detectable viral load or symptomatic HIV can be medically disqualified for a commission based on their HIV-positive status, and that should be reflected in the regulation.

Furthermore, there is no reason to include language noting that HIV-positive Service members should be evaluated on a "case by case" basis, as the revised language of DODI 6130.03 now requires. No other disqualifying medical condition is handled in this fashion under DODI 6130.03, as all people seeking accession are evaluated on an individual basis. Language requiring HIV-positive Service members seeking a commission to be evaluated on a "case by case" basis merely creates ambiguity and an opportunity for such individuals to be denied a commission based on confusion, misunderstanding, or ignorance.

Below (underlined) is proposed language for the relevant section of DODI 6130.03 that would eliminate ambiguity and ensure compliance with the injunction:

Medical Standards for Military Medical Service Appointment, Enlistment or Induction," Volume 1, Section 5: Disqualifying Conditions, 5.23 Systemic Conditions, (b):

"Presence of human immunodeficiency virus or laboratory evidence of infection for false-positive screening test(s) with ambiguous results by supplemental confirmation test(s), except for Covered Personnel (including Military Service Academy cadets and midshipmen, contracted SROTC cadets and midshipmen, and other participants in in-service commissioning programs seeking to commission while a Service member). For Covered Personnel, a Service member with an HIV diagnosis does not meet the standard only if the Service member has a detectable viral load in their most recent HIV viral load test or has symptomatic HIV."

2. **Revise DODI 6490.07 to implement the directive of the Secretary of Defense in his memorandum of June 6, 2022.**

The DOD chose not to revise DODI 6490.07 and instead merely included the directive implementing the Court's injunction regarding deployment in the policy memorandum issued on June 6, 2022. Furthermore, the Secretary included the superfluous admonition that Service members living with HIV should be evaluated for deployment on a "case-by-case" basis. All Service members are evaluated on an individual basis for medical fitness for deployment under DODI 6490.07, and there is no legitimate reason to specify that "case-by-case" evaluation is required for HIV-positive Service members. Again, the implication that something additional or different is required for Service members living with HIV will lead only to confusion, errors, and (potentially) illegal discrimination.

[1] Furthermore, the description of "covered personnel" could be incorporated into Section 5, eliminating the need for a defined term and cross-reference to its definition in a different section, but that is more of a stylistic than substantive choice and not likely to detrimentally affect the rights of Service members living with HIV.

Below (underlined) is proposed language for the relevant section of DODI 6490.07 that would eliminate ambiguity and ensure compliance with the EDVA's injunction:

Deployment-Limiting Medical Conditions for Service members and DoD Civilian Employees, Enclosure 3 (Medical Conditions Usually Precluding Contingency Deployment), (e) Infectious Diseases, (2):

(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.~~ A diagnosis of human immunodeficiency virus (HIV) with a detectable viral load or symptomatic HIV.

3. **DODI 6130.03 (Retention) should be revised to eliminate HIV exceptionalism.**

For the reasons discussed above, DODI 6130.03 (Retention) should also be revised to delete the superfluous reminder—provided only in the context of HIV—that evaluations under DODI 6130.03 are conducted on a "case-by-case" basis.

4. **Clarify that every HIV-positive Service member with an undetectable viral load and asymptomatic HIV at the time of evaluation cannot be disqualified on the basis of their HIV-positive status.**

The EDVA opinion and order made clear that any Service member with an undetectable viral load and asymptomatic HIV cannot be disqualified for deployment or commissioning on the basis of their HIV-positive status. The Court did not include any time frame over which a Service member living with HIV must maintain an undetectable viral load to fall within the parameters of the injunction. This is likely because the evidence submitted to the Court showed that 99.8% of Service members living with HIV achieve viral suppression, and no evidence was submitted regarding Service members who backslide and return to a detectable viral load. Requiring maintenance of undetectability for an as-of-yet undefined period of time, as contemplated by the Secretary's June 6 memorandum, is a violation of the EDVA's injunction.

5. **Eliminate the requirement that a Service member's HIV be "asymptomatic" to deploy or to receive a commission.**

Every Service member who is virally suppressed will be asymptomatic, as symptoms of HIV only occur during the initial stage of infection and (potentially) if the person's CD4 count later drops to very low levels. For that reason, the term "asymptomatic" is no longer typically used by medical professionals in assessing the health status of individuals living with HIV. Given its previous use in the DOD's regulations regarding HIV, it is understandable why this terminology was included in the EDVA's injunction; however, infectious disease specialists have advised that it is redundant to require that an individual be both virally suppressed and asymptomatic. Plaintiffs' counsel would be happy to provide references to multiple infectious disease specialists who will confirm this. Retaining the requirement that

the Service member be asymptomatic will not advance any legitimate goal but could lead to confusion and errors on the part of those conducting the relevant medical evaluations.

6. **Change the standard for Service members to commission and to deploy to a viral load of <500 copies/ml instead of an "undetectable" viral load.**

Though an "undetectable" viral load is the ultimate goal of treatment and is popularly understood to be the level at which a person's HIV is no longer transmissible sexually (thanks to the U=U campaign), all of the benefits of treatment—including zero risk of transmission—are very likely achieved at a viral load as high as 1000 copies/ml. In fact, testing "blips" in which an individual's viral load pops above the level of undetectability (but are still under 1000) are not uncommon and do not alarm HIV care providers or require any action on their part. Furthermore, the term "undetectable" is not constant, as the number of copies per milliliter changes based on improvements in the sensitivity of the testing technology (and is poised to move below the 20 copies/ml at which it has resided for more than a decade). In 2010, the Society of Healthcare Epidemiologists of America (SHEA) set the standard at 500 copies/ml for healthcare workers living with HIV to perform exposure-prone, invasive procedures (https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/management-of-healthcare-personnel-living-with-hepatitis-b-hepatitis-c-or-human-immunodeficiency-virus-in-us-healthcare-institutions/71C331662FBEDDF7F62369E22A22E4F0) Plaintiffs request that the DOD follow the lead of this very well-respected organization that issues widely followed occupational health standards and set the DOD standard for deployment and commissioning of Service members living with HIV at the same level.

7. **Create an ombudsperson within the DOD to address HIV-related inquiries across the various branches**

The U.S. military is a huge operation with thousands and thousands of employees, and it will undoubtedly take time for the changes in the regulations related to Service members living with HIV to be fully disseminated and absorbed. Plaintiffs experienced a lot of personnel who were uncertain or confused about how to handle personnel living with HIV and have heard from many other Service members living with HIV who have had similar experiences. The sudden changes in the regulations—as well as the remaining inconsistencies—will likely only exacerbate some of that uncertainty and confusion. For these reasons, Plaintiffs ask that the DOD appoint an ombudsperson with whom personnel may consult when attempting to understand and apply the new policies regarding Service members living with HIV and to whom Service members living with HIV may turn if encountering problems or barriers to their full service based on their HIV status.

We look forward to hearing from you regarding the above detailed requests. Furthermore, Plaintiffs' counsel would like to discuss potential changes to the regulations to allow for the enlistment and appointment of people living with HIV who are not currently serving. Fruitful engagement on these issues may obviate the need for further litigation to achieve the stated goals of the Biden administration on this subject.

Sincerely,

/s/ *John W. H. Harding*

Cc: Julie Bauer, Esq.
Lauren Gailey, Esq.
Andrew Sommer, Esq.
Scott Schoettes, Esq.
Peter Perkowski, Esq.
Kara Ingelhart, Esq.
Greg Nevins, Esq.

Exhibit 16

November 22 Letter

Perkowski LEGAL

515 S. Flower Street, Suite 1800
Los Angeles, CA 90071

PETER E. PERKOWSKI
o: 213.340.5796
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CONFIDENTIAL –
CONTAINS NON-PUBLIC INFORMATION

November 22, 2022

By Email Only

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Eastern District of Virginia
2100 Jamieson Ave.
Alexandria, VA 22314

Re: *Harrison v. Austin*, No. 1:18-cv-651; *Roe et al. v. Austin*, No. 1:18-cv-1565

Counsel:

This is to inform you of several matters showing Defendants' non-compliance with the permanent injunctions issued in the above-captioned matters. As detailed below, service members with HIV[1] are still—over seven months since the Court's order—facing barriers to assignment, deployment, and commissioning because of their HIV status. Given that the injunctions apply not just to the named plaintiffs but also "any other asymptomatic HIV-positive service member with an undetectable viral load" (Amended Orders, at 1 (emphasis added)), we write to alert you to these issues and seek immediate action that achieves compliance with the Court's directives.

Continued restrictions on deployment and commissioning of service members with HIV

We have received reports that the Army and Navy are restricting opportunities, duty assignments, and deployments to Soldiers and Sailors based on HIV status.

SGT REDACTED**.** Sergeant REDACTED's unit will deploy to the Middle East on the day after Christmas. But he has been informed that he will not be joining them because CENTCOM denied his request for a waiver for HIV.

Sergeant REDACTED serves in REDACTED Company, REDACTED Battalion (REDACTED) of the REDACTED Army National Guard (REDACTED ARNG), which has received orders to deploy to the Middle East. Sergeant REDACTED is living with HIV, and with the full support of his chain of command—company leadership as well as Battalion and State Guard officers—Sergeant REDACTED prepared and submitted a waiver request showing that he is healthy and maintaining an undetectable viral load.[2]

[1] The service members discussed in this letter have requested that their names be kept non-public. We share them to facilitate a prompt resolution.

[2] The waiver also noted a prescription for hypercholesterolemia, atorvastatin, which Sergeant REDACTED takes daily with his HIV medication to prevent him from developing high cholesterol. Neither MOD16 nor DoDI 6490.07, which governs deployment-limiting medical conditions, lists conditions characterized by a high level of blood lipids (hypercholesterolemia or hyperlipidemia) as disqualifying for deployment.

The [REDACTED] ARNG waiver authority, Deputy State Surgeon General COL [REDACTED] approved the request and forwarded it to CENTCOM for further approval, in accordance with MOD16 to the USCENTCOM Individual Protection and Individual/Unit Deployment Policy. But on November 21, his unit leadership informed Sergeant [REDACTED] that CENTCOM had denied his waiver request in a communication to [REDACTED] ARNG medical command. As of this writing, CENTCOM had provided no explanation for the denial, and there appears to be none other than the mere fact that Sergeant [REDACTED] is living with HIV.

There is no basis for refusing Sergeant [REDACTED] a medical waiver, as his HIV is asymptomatic and his viral load is undetectable; when those criteria are met, the Court has ruled that defendants may not preclude service members from deploying to CENTCOM. Yet from all appearances, CENTCOM continues to bar service members with HIV from deploying to that command. Defendants must reverse the decision denying the waiver for Sergeant [REDACTED] and confirm that they will discontinue the practice of denying waivers in a manner at odds with the permanent injunctions. (We address below the larger non-compliance issues raised by Defendants' waiver requirement.)

The [REDACTED] will commence deployment on December 26; we understand that Sergeant [REDACTED] has until then to obtain a waiver, or he will be taken off orders. Because of this narrow window, and to allow time to seek appropriate relief from the Court, we will need to know as soon as possible whether defendants will grant Sergeant [REDACTED]'s waiver.

1LT [REDACTED]. Lieutenant [REDACTED] recently completed [REDACTED] of the Army's Graduate Program in [REDACTED] but he has been prevented from joining or even interviewing with certain units as his next assignment because he is classified as non-deployable due to HIV.

Lieutenant [REDACTED] is currently assigned to [REDACTED], [REDACTED], [REDACTED]. Recently, while in his Assignment Interactive Module (AIM) cycle, Lieutenant [REDACTED]'s career manager advised him that, to advance his career, he needed to be assigned to a deployable unit. But he encountered a roadblock: his Medical Readiness Classification (MRC) code shows him as non-deployable, so he could not get interviews for open positions in deployable units.

To solve this problem, Lieutenant [REDACTED] spoke to Anthony B. Clark, Chief, Policy Procedures & Special Actions Branch of Army Human Resources Command (HRC). Mr. Clark confirmed that he was aware of new DoD policies governing the deployability of service members with HIV. The new policies had no effect, however. Instead, Mr. Clark told Lieutenant [REDACTED] that "even though the policy has changed, the policy is still the same." The clear meaning of Mr. Clark's statement is that the Army is refusing to implement the Court's rulings and is not changing how it does business. This is confirmed by another statement that Mr. Clark made to Lieutenant [REDACTED] that the Army "will not change" how it applies MRC codes for Soldiers with HIV. This is squarely at odds with the permanent injunctions.

As to career goals, Mr. Clark advised Lieutenant [REDACTED] that he needed to seek an ETP to even be considered for an assignment to a deployable unit. But an ETP would take at least 90 days to process, and Lieutenant [REDACTED]'s AIM cycle was closing. Lieutenant [REDACTED] spoke to numerous people at Army HRC to work through these issues—including MSG Teddy Lee Fain III, HRC Surgeon Sr. Medical NCO, and MAJ Stephanie Gasper, HRC Career Manager for his career field ([REDACTED])—to no avail. Lieutenant [REDACTED]'s deadline to apply for positions ended on November 14 without resolution of this issue.

SFC [REDACTED]. Sergeant [RED ACT] is facing a similar problem with his application to the Enlisted to Medical Degree Preparatory Program (EMDP2), which would lead to a commission. As with Lieutenant [REDACTED] Sergeant [RED ACT]'s MRC code shows him as non-deployable, and to complete his EMDP2 application he had to submit to the admissions committee a Soldier Record Brief (SRB), which contains his MRC code. Sergeant [RED ACT] is worried that the MRC code will cause Sergeant [RED ACT]'s application to be rejected because he will be seen as non-deployable or unable to commission.

The Army's refusal to change the way it applies MRC codes for Soldiers living with HIV is causing intractable problems for those who are trying to obtain duty assignments in deployable units or applying to commissioning programs. Maintaining these MRC codes for Soldiers with HIV also violates the Court's injunctions in *Harrison* and *Roe* by branding them as categorically non-deployable.[3] This is unacceptable.

Continued restrictions placed on service members living with HIV

We have learned that the Navy[4] is refusing a Sailor a billet based on his HIV status, in violation of the permanent injunctions in *Harrison* and *Roe*.

In 2021, [REDACTED] applied for a special-duty billet in the Defense Courier Service (DCS), a prestigious and highly coveted assignment. He passed the medical screening and financial counseling, and he received Top Secret clearance. When it came time for his detailer to cut orders, however, Petty Officer [REDACTED] was flagged for medical reasons—specifically, for HIV. Petty Officer [REDACTED] had asked to be stationed in Sicily, but the detailer's commander—LCDR Ryan Peterson—informed Petty Officer [REDACTED] that the job might require him to deliver mail into Bahrain and Iran, which LCDR Peterson claimed was not permitted due to Petty Officer [REDACTED]'s HIV status. Petty Officer [REDACTED] made LCDR Peterson aware of Secretary Austin's June 6, 2022 Memorandum Re: Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces (HIV Memo), but it made no difference. In an email, LCDR Peterson acknowledged being aware of the HIV Memo, but wrote: "As things are now yes, you are deployable. But currently per MILPERSMAN 1300-1300 that is limited to platforms with a fulltime medical officer assigned to it. … We'll see if that changes when the new [Navy] instruction is released."

As explained below, the Navy's treatment of Petty Officer [REDACTED]'s reassignment request shows both systemic and case-specific problems with Defendants' compliance with the Court's injunctions.

***Systemic issues*:** Petty Officer [REDACTED]'s experience, like Lieutenant [REDACTED]'s, demonstrates that the HIV Memo has not resulted in changes to Service-level policy or practice. The Memo states that its changes are "effective immediately," and the Court's orders contain no grace period during which the DoD can continue to harm service members with HIV while awaiting the issuance of Service-level regulations. Nevertheless, local commanders insist on waiting for them. And those regulations are inexplicably late: the Memo requires conforming updates within 60 days, but the Services are well over 90 days past that deadline.

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[3] The MRC codes—and codes from other Services like the Air Force's Assignment Limitation Code (ALC)—don't just limit a service members' ability to deploy and commission. They also require repeated disclosure of HIV status to secure the benefits of equal treatment the Court has already mandated. This too is unacceptable.

[4] Though the Navy was not named in *Harrison* or *Roe*, the injunctions were directed to the Department of Defense and therefore protect all service members, regardless of military department.

Nor has the Memo had the purportedly intended effect of changing practices at the command level—where decisions about service members with HIV are made—even when it is expressly brought to the attention of and made available to the decisionmaker. Decisionmakers appear unable or unwilling to understand the sweeping nature of the changes required by the injunctions, perhaps due to the convoluted way in which the DoD implemented them, as discussed in the letter on this subject that Plaintiffs' counsel sent on July 1, 2022. As a result, decisionmakers—at the very least Petty Officer Sandoval's decisionmakers—seem to be under the impression that changes to DoD regulations leave the Services with latitude to deny service members with asymptomatic HIV and an undetectable viral load some assignments or deployments based on their HIV status.

***Case-specific issues*:** The reasoning behind the Navy's denial of Petty Officer REDACTED's DCS assignment also demonstrates non-compliance with the injunctions. MILPERSMAN 1300-1300 lists Sigonella, Italy—the Sicily base that Petty Officer REDACTED selected as his billet—as a command eligible for operational assignment for people with bloodborne pathogens, so that regulation was not the reason Petty Officer REDACTED was denied. Rather, LCDR Peterson indicated that the underlying reason for the denial was that decisionmakers were not comfortable with allowing a person with HIV to travel into Bahrain and Iran. When Petty Officer REDACTED pointed out that he had previously traveled on military papers into Bahrain and even had liberty there, LCDR Peterson said he "didn't want to hear that" and reiterated that he and his superior no longer supported Petty Officer REDACTED's placement in the billet. Petty Officer REDACTED tried again to convince LCDR Peterson by asking if others in the billet could be given any assignments requiring travel through Bahrain and Iran, but LCDR Peterson again shut him down, saying it was "just too much risk."

That LCDR Peterson invoked unspecified "risk" as the reason for denying Petty Officer REDACTED's billet should ring familiar: the Court *rejected* that speculative and unsupported justification while invalidating Defendants' prior practice of barring service members with HIV from deploying. The Court also expressly gave no credence to Defendants' speculative and unsupported contention that some foreign country restrictions might prohibit or complicate the entry of service members with HIV. (*See* Opinion, at fn.22.) These deeply ingrained but likely misinformed and inaccurate beliefs among everyday military functionaries cannot be used to avoid the mandate of the Court's injunctions. In a case-by-case, waiver-dependent system where a single decisionmaker holds outsize power to deny requests, misinformed and inaccurate beliefs likely will continue to negatively affect service members with HIV seeking a wide range of assignment, deployment, and commissioning opportunities. Again, we address below the larger non-compliance issues raised by Defendants' procedural waiver requirement.

In fact, LCDR Peterson's concerns about the laws of Bahrain and Iran are misinformed and incorrect. People living with HIV are *not* prohibited from entering those countries. The U.S. State Department states that it is "unaware of any HIV/AIDS entry restrictions for visitors to Iran,"[5] and holders of diplomatic, service, or special passports are exempt from any work or residency restrictions that do apply.[6] Similarly, Bahraini restrictions apply only to people staying in country for longer than 90 days, which would not be necessary in Petty Officer REDACTED's role as a courier. Bahrain's restrictions also likely do not apply at all to diplomatic and official passport holders like

[5] https://travel.state.gov/content/travel/en/international-travel/International-Travel-Country-Information-Pages/Iran.html

[6] https://www.hivtravel.org/Default.aspx?PageId=143&CountryId=89

DoD personnel.[7] Learning of Petty Officer REDACTED's previous entry into Bahrain should have cued LCDR Peterson to reexamine his inaccurate beliefs; instead, he refused to consider that new information and doubled down on his mistaken concerns.

Given these facts, LCDR Peterson's refusal to approve Petty Officer REDACTED's DCS assignment boils down to the same baseless speculation and generalized concerns that the Court rejected in its rulings against Defendants' prior practices. These facts also show that the restriction Petty Officer REDACTED faces is a categorical bar. In the HIV Memo, Secretary Austin described the "update[d] DoD policy" as follows: "Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load … *will have no restrictions applied to their deployability* or to their ability to commission while a service member solely on the basis of their HIV-positive status" (emphasis added). But that standard is not being applied to Petty Officer REDACTED Rather, the decision to deny him a coveted billet was not made based on individualized circumstances, nor does it depend on his qualifications to perform the job or the particulars of his HIV (for example, a detectable viral load). Instead, it would be applied to anyone with HIV and therefore violates the clear mandate of the *Harrison* and *Roe* injunctions.

As soon as this week, Petty Officer REDACTED will face the prospect of giving up the DCS assignment to pursue other, less attractive options. Because his window is closing, please let us know as soon as possible whether Defendants will reverse the decision as to Petty Officer REDACTED

The DoD's regulations requiring waivers to deploy or commission

The problems recounted above, and doubtless many others we have not heard about, arise because of Defendants' decision to implement the Court's order by requiring service members living with HIV to obtain waivers before being considered eligible to deploy or commission. But this revised regulatory arrangement is merely the old HIV bar dressed up in new administrative burdens. And while it may (and should) result in at least some service members with HIV being allowed to deploy and commission, it does not comply with the Court's injunction for the following reasons.

First, using waivers to perform gatekeeping is a categorical bar: Service members with HIV are uniformly classified as non-deployable or not commissionable unless and until (1) they submit a request for a waiver—a process that itself is onerous and time-consuming, requiring the support and approval of multiple decisionmakers in a long chain of command, some of whom may be misinformed about HIV medical science or unaware of the DoD's new policies in this area, and (2) that waiver is granted. This system *will* result in some service members being denied opportunities due to HIV status; in fact, it already has, as shown by the experiences of Lieutenant REDACTED and Sergeant REDACTED above. And because 99.8% of service members with HIV achieve an undetectable viral load, the ones who are denied opportunities will suffer that consequence even though the Court found that there was no rational basis for limiting their ability to deploy and commission.

In fact, the new procedural requirement is also contrary to the Court's ruling. As a textual matter, the Court's opinion and orders do not give Defendants the latitude to refuse to deploy or commission any service member who meets two identified criteria (asymptomatic and

[7] https://www.hivtravel.org/Default.aspx?PageId=143&CountryId=25; https://travel.state.gov/content/travel/en/international-travel/International-Travel-Country-Information-Pages/Bahrain.html

undetectable). Such a refusal would be an absurd result given the Court's factual findings and its rejection of *all* Defendants' justifications for the prior policy. As noted above, the Secretary's own HIV Memo confirms Defendants' understanding of the new operational standard that the Court's orders demand: service members who meet the criteria may not be prevented from deploying or commissioning. Yet the current waiver system forces every service member with HIV to re-prove what Plaintiffs spent hundreds of thousands of dollars in legal work and four years of litigation to prove in court: that they should be allowed to deploy or commission if they are asymptomatic and have an undetectable viral load.

Second, the Court did not intend its ruling to result in a system where service members with HIV are relegated to a second-class status that requires them to clear administrative hurdles even when they are asymptomatic and have an undetectable viral load. The Court's opinion made this clear by comparing Defendants' treatment of HIV to other chronic conditions *that do not require a waiver*:

> In stark contrast to the military's treatment of HIV-positive service members, service members with various chronic but manageable conditions can qualify for accession and deployment *without a medical waiver* based on individualized considerations of the severity of their diagnoses which are expressly set out in the relevant Department of Defense Instructions. For example, most individuals with dyslipidemia can qualify for accession and deployment *without a medical waiver* even if they have to take daily medication as long as [the condition is within certain criteria]. Similarly, it appears that most individuals with a history of Gastro-Esophageal Reflux Disease can qualify for accession and deployment *without a medical waiver* even if they have to take daily medication as long as they [satisfy certain medical criteria associated with the condition].
>
> In addition, most service members with vision impairment can qualify for accession and deployment *without a medical waiver* as [their corrected vision meets certain standards]. Lastly, most individuals with asthma can qualify for deployment *without a medical waiver* even if they have to take daily medication as long as [the condition is within certain guidelines]. (Opinion, at 28-29 (citations and footnotes omitted) (emphases added).)

Third, even assuming that the procedural requirement of securing a waiver is not itself a violation of equal protection, Defendants' revised regulations fail to specify any standard under which waivers should be considered and decided—namely, that the waiver should be granted if applicants demonstrate that they have asymptomatic HIV and their viral load is undetectable. The failure to specify a standard is an invitation for mischief, as applications with waiver requests are often viewed with disfavor, while misinformed or biased commanders have the authority to delay or deny waivers without explanation, thus circumventing the Court's injunction.

To avoid the legal and practical problems that arise with the new waiver system, Defendants must make service members with asymptomatic HIV and undetectable viral load *presumptively* able to deploy and commission, just as service members with other chronic medical conditions who meet certain health metrics are presumptively able to deploy and commission. Defendants can do this in a way that is administratively much simpler than the current case-by-case waiver system. Namely, all service members with HIV are subject to routine, periodic medical testing and evaluation to monitor their HIV. Medical flags like the MRC and ALC codes should be applied to them only upon

initial diagnosis, then removed once they achieve an undetectable viral load and symptoms (if any) subside, and then reimposed only when periodic testing reveals that they no longer meet those criteria. If necessary, routine pre-deployment testing and assessments, such as DD Form 2795 and related DoDIs, can be modified to ensure that the asymptomatic and undetectable criteria are still present before a service member with HIV deploys, thus replacing medical flags and codes that presumptively categorize them as non-deployable. This process will satisfy the Court's rulings and allow service members with HIV to fully engage and progress in their careers on the same basis as their counterparts, without unnecessary gatekeeping and administrative burdens—like those described above—that will often impose on them the very same restrictions that the Court already struck down.

* * *

Accordingly, please inform us as soon as possible, but no later than the close of business on Tuesday, November 29, whether Defendants will lift the HIV-related restrictions on Sergeant REDACTED and Petty Officer REDACTED Furthermore, please inform us immediately whether Defendants will dismantle their problematic and non-compliant waiver system for service members with HIV in favor of a system that makes them presumptively eligible to deploy and commission. If not, please let us know when you are available for a pre-motion conference so that we can discuss these issues before bringing them to the Court's attention through motion practice.

Best regards,

Peter E. Perkowski

c: John Harding
Julie Bauer
Lauren Gailey
Andrew Sommer
Scott Schoettes
Kara Ingelhart
Greg Nevins

Exhibit 17

Dec. 20 Email

Peter Perkowski

From: Peter Perkowski <peter@perkowskilegal.com>
Sent: Tuesday, December 20, 2022 5:26 PM
To: 'Berman, Keri L. (CIV)'; 'Abbuhl, Joshua (CIV)'; 'Barghaan, Dennis (USAVAE)'
Cc: 'Harding, John'; 'Bauer, Julie'; 'Gailey, Lauren'; sommera@gtlaw.com; 'Scott Schoettes'; 'Kara Ingelhart'; 'Greg Nevins'
Subject: RE: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565
Attachments: REDACTED_MOD16_Tab_C_denied.pdf; Kuwait Travel Restriction.pdf

Importance: High

Counsel:

Do you have an update on any of the individuals mentioned in our letter concerning defendants' non-compliance with the Court's injunctions, which was sent nearly one month ago? As you know, for two of these individuals the situation is extremely time-sensitive, and further delay will prejudice them and their careers indelibly.

We have the following additional information to share on defendants' compliance problems:

We have been informed that SGT REDACTED's waiver has (supposedly) been denied. A document purporting to be a waiver denial is attached. But the person signing the waiver denial—a COL Janet Chenault—does not appear to be the CENTCOM waiver authority. MOD16 gives waiver authority to the CENTCOM Surgeon (or, upon delegation, to CENTCOM Service Component Surgeons). By contrast, COL Chenault is Chief of Health Readiness at Army Central Command (ARCENT). Please let us know under what authority COL Chenault was acting.

In addition, the reason given for the waiver denial appears to be a pretext, or at the very least inaccurate. COL Chenault states that "The country of Kuwait does not allow individuals with this diagnosis to enter/stay in the country of Kuwait," citing to and quoting from Department of State travel guidance that pertains to "visitors" and "foreign residents." The only restrictions quoted, however, are specific to residents: namely, "residence permits" require an HIV test and "residents" who are found to be HIV+ will be required to leave the country. But SGT REDACTED will not be a Kuwait resident, and these restrictions therefore do not apply to him. Moreover, the DoD's own entry requirements for Kuwait—a document far more relevant here than State Department guidance—appear to contradict COL Chenault. That document (attached) states that "Country clearance [is] not required" for DoD personnel who are going to Kuwait on PCS/TCS orders, or for personnel "on contingency deployment orders." (Section III.A.1.a(1)(f).) Even if those clearance exceptions did not apply here, though, it still does not mean that servicemembers with HIV can't be cleared. In fact, the section called "Content of A Clearance Request" does not refer to medical information. (See Section III.E.) Finally, neither the Section on "Immunizations and Other Medical Requirements," nor any of the linked sites in that Section, refers to HIV medical exclusions. In short, DoD entry requirements for Kuwait do not restrict people with HIV from deploying there. COL Chenault's waiver denial is ultra vires and without basis.

Finally, a few questions: The waiver denial is dated 5 December, four days before our meet-and-confer on 9 December. Were you aware of this document during that phone call? In discussions with his unit command, SGT REDACTED was told that an email had been sent to the effect that, in essence, *DOJ* had provided the "all clear" to deny the waiver. Can you shed any light on DOJ's involvement in providing the basis or clearance for SGT REDACTED's waiver denial? Also, you mentioned on our call that a different servicemember with HIV was granted a CENTCOM waiver. Can you share to what country that person was deploying, or provide any other information about why one waiver was granted and another denied? Without such information, the only conclusion to be drawn from the information we have is that *all* servicemembers with HIV will be restricted from entering Kuwait, which as the staging area for most CENTCOM

deployments would mean that nearly all servicemembers with HIV will be restricted from deploying to CENTCOM. It's hard to square this information with your recent statement that defendants are in compliance with the Court's injunctions.

SGT REDACTED will be taken off orders on December 22. Please respond before then.

We have also learned that there is at least one additional person in SGT REDACTED's battalion who is living with HIV and is facing the same issue. (There were actually two, but one of them failed to obtain a security clearance.) That person had not yet submitted a waiver, as RE ARNG is waiting to see how SGT REDACTED's waiver was handled. We are trying to get additional information about this Soldier.

We also request an update regarding REDACTED.

Again, it has been nearly a month since we informed you of these problems. The government's inability to provide any substantive information in that timeframe is unjustifiable.

Best regards,

Peter E. Perkowski (*he/him, Mr./Mx.*)
o: **+1 (213) 340-5796** | m: **+1 (323) 707-3154**
peter@perkowskilegal.com | **web**
Admitted in CA, DC, and NY

From: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>
Sent: Wednesday, December 7, 2022 10:55 AM
To: Peter Perkowski <peter@perkowskilegal.com>; Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Barghaan, Dennis (USAVAE) <Dennis.Barghaan@usdoj.gov>
Cc: 'Harding, John' <jwharding@winston.com>; 'Bauer, Julie' <jbauer@winston.com>; 'Gailey, Lauren' <lgailey@winston.com>; sommera@gtlaw.com; 'Scott Schoettes' <sschoettes@gmail.com>; 'Kara Ingelhart' <kingelhart@lambdalegal.org>; 'Greg Nevins' <gnevins@lambdalegal.org>
Subject: RE: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565

Hi Peter,

Are Plaintiffs available on Friday at 2pm est for the call you requested?

Best,
Keri

From: Peter Perkowski <peter@perkowskilegal.com>
Sent: Tuesday, December 06, 2022 1:40 PM
To: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; Barghaan, Dennis (USAVAE) <DBarghaan@usa.doj.gov>
Cc: 'Harding, John' <jwharding@winston.com>; 'Bauer, Julie' <jbauer@winston.com>; 'Gailey, Lauren' <lgailey@winston.com>; sommera@gtlaw.com; 'Scott Schoettes' <sschoettes@gmail.com>; 'Kara Ingelhart' <kingelhart@lambdalegal.org>; 'Greg Nevins' <gnevins@lambdalegal.org>
Subject: RE: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565

Josh:

Today marks two weeks since our letter outlining individual and systemic problems with the implementation of the injunctions in *Harrison* and *Roe*. We appreciate your update from last week and readily agreed to your request for additional time to gather the information necessary to formulate defendants' response, we are constrained in how long we can wait for a response. Because of the time-sensitive nature of the issues and the potential to irreversibly change some people's careers, we must insist on moving forward with a meet-and-confer as soon as possible. Even apart from the urgency to resolve issues for some individual Service members, we have grave concerns that the systemic problems we identified will continue to have negative effects on others that we don't know about.

Accordingly, please share your availability for a telephonic meeting on Thursday and Friday of this week. If you would like to provide a written response to our November 22 letter before then, we would be grateful to consider it.

Thank you for your attention to this matter.

Very respectfully,

New office phone number as of 12-1-2021

Peter E. Perkowski (*he/him, Mr./Mx.*)
o: **+1 (213) 340-5796** | m: **+1 (323) 707-3154**
peter@perkowskilegal.com | **web**
Admitted in CA, DC, and NY

From: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>
Sent: Tuesday, November 29, 2022 2:35 PM
To: Peter Perkowski <peter@perkowskilegal.com>; Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; Barghaan, Dennis (USAVAE) <Dennis.Barghaan@usdoj.gov>
Cc: 'Harding, John' <jwharding@winston.com>; 'Bauer, Julie' <jbauer@winston.com>; 'Gailey, Lauren' <lgailey@winston.com>; sommera@gtlaw.com; 'Scott Schoettes' <sschoettes@gmail.com>; 'Kara Ingelhart' <kingelhart@lambdalegal.org>; 'Greg Nevins' <gnevins@lambdalegal.org>
Subject: RE: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565

Peter,

Following up on my email below, I wanted to let you know that we have been gathering information relevant to your letter since we received it last Tuesday, particularly about Sgt. REDACTED and REDACTED. We are moving as fast as we can, but we still are gathering information and are not yet able to provide a full response at this time. I will revert with a fuller response as soon as we can give you one, and we are aware that you indicated the subjects of your letter are time-sensitive.

Best,
Josh

From: Abbuhl, Joshua (CIV)
Sent: Wednesday, November 23, 2022 10:50 AM
To: 'Peter Perkowski' <peter@perkowskilegal.com>; Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; Barghaan, Dennis (USAVAE) <DBarghaan@usa.doj.gov>
Cc: 'Harding, John' <jwharding@winston.com>; 'Bauer, Julie' <jbauer@winston.com>; 'Gailey, Lauren' <lgailey@winston.com>; sommera@gtlaw.com; 'Scott Schoettes' <sschoettes@gmail.com>; 'Kara Ingelhart' <kingelhart@lambdalegal.org>; 'Greg Nevins' <gnevins@lambdalegal.org>
Subject: RE: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565

Peter,

Confirming receipt of your letter. We forwarded the letter to DoD last night and are looking into the questions you raised. We will reply as soon as we are able.

Josh

From: Peter Perkowski <peter@perkowskilegal.com>
Sent: Tuesday, November 22, 2022 4:58 PM
To: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; Barghaan, Dennis (USAVAE) <DBarghaan@usa.doj.gov>
Cc: 'Harding, John' <jwharding@winston.com>; 'Bauer, Julie' <jbauer@winston.com>; 'Gailey, Lauren' <lgailey@winston.com>; sommera@gtlaw.com; 'Scott Schoettes' <sschoettes@gmail.com>; 'Kara Ingelhart' <kingelhart@lambdalegal.org>; 'Greg Nevins' <gnevins@lambdalegal.org>
Subject: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565

Counsel:

Please see the attached correspondence.

Best regards,

New address and office phone number as of 12-1-2021

Peter E. Perkowski (*he/him, Mr./Mx.*)

Perkowski Legal, PC
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Exhibit 18

Dec. 22 Email

Peter Perkowski

From: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>
Sent: Thursday, December 22, 2022 12:35 PM
To: Peter Perkowski; Berman, Keri L. (CIV); Barghaan, Dennis (USAVAE)
Cc: 'Harding, John'; 'Bauer, Julie'; 'Gailey, Lauren'; sommera@gtlaw.com; 'Scott Schoettes'; 'Kara Ingelhart'; 'Greg Nevins'
Subject: [Not Virus Scanned] [Not Virus Scanned] RE: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565
Attachments: REDACTED_waiver response CCSG PW 101993 (2).pdf; Waiver_Redacted.pdf

This message has not been virus scanned because it contains encrypted or otherwise protected data. Please ensure you know who the message is coming from and that it is virus scanned by your desktop antivirus software.
This message has not been virus scanned because it contains encrypted or otherwise protected data. Please ensure you know who the message is coming from and that it is virus scanned by your desktop antivirus software.
Peter,

Thank you for your email. We will relay as much as we can at this time, especially about Sgt. REDACTED but we will need to follow-up later about some of the other questions you raise. As we said during our previous meet-and-confer, although the Secretary of Defense's June 6th policy memorandum changed DoD policy consistent with the district court's order, the military's downstream implementation of the policy memorandum is still ongoing, and certain aspects of the military's policies with respect to HIV remain in flux. Thus, we are continuing to gather information about a still-developing policy area, which is made more difficult because many of our clients' employees are unavailable due to pre-planned holiday leave. Still, we wish to continue working with you in the hopes of avoiding unnecessary motions practice.

Nonetheless, we can reiterate – consistent with our statements in the meet-and-confer – that the military remains in compliance with the injunction. As we discussed during the meet-and-confer, the injunction in relevant part enjoins the military from "categorically barring the worldwide deployment or deployment to the United States Central Command ('CENTCOM') of . . . any . . . asymptomatic HIV-positive service member with an undetectable viral load due to their HIV-positive status." ECF No. 314, at 1. From what we have gathered so far, the military does not employ any such categorical bar.

Before getting into the substance of Sgt. REDACTED's waiver request, we will address the concerns you raised relating to the authority of the person denying his waiver. You provided a document signed by Colonel Janet Chenault, who works at ARCENT. We understand that COL Chenault recommended denial of the request and sent that form to CENTCOM, after which CENTCOM also denied the request and sent back a document bearing a CENTCOM representative's signature. We have attached that latter document here (the password is in the title: REDACTED). In light of the attached CENTCOM document denying Sgt. REDACTED's waiver, please let us know if you have any further concerns about the authority of the decisionmaker.

As for the substance of Sgt. REDACTED's denial, it was not based on the medical concerns that were the primary subject of litigation in the *Roe/Harrison* cases. Rather, the waiver denial states that Sgt. REDACTED "[m]eets USCENTCOM entry requirements for HIV" and then cites concerns grounded in Kuwaiti laws regarding HIV and State Department guidance concerning those laws as a basis to deny the waiver. Our current understanding is that CENTCOM looks at each waiver request and determines whether a particular deployment to a particular country is proper based on various concerns, including host-country laws. In Sgt. REDACTED's case, CENTCOM decided that concerns related to Kuwaiti law warranted a denial of Sgt. REDACTED's waiver request. That is not a "categorical" bar to deployment to CENTCOM. Moreover, your email references that during the meet-and-confer we noted that another individual was granted a deployment waiver to CENTCOM. We have attached that waiver here, with the PII of the individual removed. As you can see, the individual was

a civilian (not a service member) and the waiver request, which pre-dated Sgt. REDACTED's request, was approved to deploy to Iraq. We have not yet been able to determine whether that individual ended up traveling to Iraq (he may not have), but in any event the waiver reflects that the deployment (or potential deployment) to Iraq was approved by CENTCOM.

Your email asserts that "the reason given for the waiver denial appears to be a pretext, or at the very least inaccurate." We do not see any further explanation in your email to support your statement that the reason given for the denial is pretextual, and we are not aware of any basis for that contention. While we may dispute how Kuwaiti law would implicate someone in Sgt. REDACTED's situation, we note for now that your email mainly discusses your understanding of Kuwaiti entry requirements, while the CENTCOM waiver denial cites State Department guidance that says, among other things, "[i]f HIV-related illness becomes known, the resident must leave the country or be deported." *See* https://travel.state.gov/content/travel/en/international-travel/International-Travel-Country-Information-Pages/Kuwait.html.

We understand that the reason you asked for a response from us by today is due to the timing of the deployment of Sgt. REDACTED's unit. Your email suggests that this situation is "extremely time-sensitive, and further delay will prejudice [Sgt. REDACTED's] career[] indelibly." While we respect Sgt. REDACTED's desire to serve his country on this deployment, we respectfully disagree that this matter is time-sensitive in the way you suggest, or that the denial of the waiver would "indelibly" affect Sgt. REDACTED's career. We understand from our military colleagues that Sgt. REDACTED is a highly respected member of his unit and that the REDACTED National Guard is willing to work with him to help him identify appropriate career opportunities, including any future deployment opportunities should they arise. Sgt. REDACTED's HIV-status does *not* mean he cannot deploy or that he cannot deploy to CENTCOM. Rather, it only means that he cannot deploy to those countries that raise certain specific concerns regarding his HIV status, such as Kuwait. Indeed, we understand that Sgt. REDACTED's unit has already spoken to him about a possible deployment to Djibouti in the near future. Therefore, we do not think he is meaningfully or irreparably harmed if he is unable to participate in this particular deployment. We also think that grounding the time-sensitivity on this issue based on the December 26 deployment date is misplaced; we understand that December 26 is the date that the unit will travel to Texas for pre-deployment training, which will take at least two weeks, and that portions of the unit are not planning to deploy until mid-to-late January. (And we further understand that there are more than 100 other members of Sgt. REDACTED's unit who also will not participate in this deployment.)

Although nearly all of your email was devoted to Sgt. REDACTED's situation, we recognize that you also requested an update regarding REDACTED. We have inquired about REDACTED's situation but unfortunately we have had greater difficulty in gaining information about his status, largely because the person who was most responsible for handling his assignments is on leave. Nonetheless, we can report that based on what we have learned so far, we believe that REDACTED has received new orders. We are still tracking down the details and will revert when we have more information.

We would appreciate another opportunity to meet-and-confer before any motions' practice. We are available either later today or tomorrow. Please let us know what times would work for you.

Regards,
Josh

From: Peter Perkowski <peter@perkowskilegal.com>
Sent: Wednesday, December 21, 2022 11:36 AM
To: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; Barghaan, Dennis (USAVAE) <DBarghaan@usa.doj.gov>
Cc: 'Harding, John' <jwharding@winston.com>; 'Bauer, Julie' <jbauer@winston.com>; 'Gailey, Lauren' <lgailey@winston.com>; sommera@gtlaw.com; 'Scott Schoettes' <sschoettes@gmail.com>; 'Kara Ingelhart' <kingelhart@lambdalegal.org>; 'Greg Nevins' <gnevins@lambdalegal.org>
Subject: RE: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565

Hi Josh. Yes, confirming the below. I continue to represent the individuals, I have their permission to share and receive information from DOJ/DOD, and each of them has given me permission to share information with the rest of the litigation team as well.

Thank you.

V/r,

Peter E. Perkowski (*he/him, Mr./Mx.*)
o: **+1 (213) 340-5796** | m: **+1 (323) 707-3154**
peter@perkowskilegal.com | **web**
Admitted in CA, DC, and NY

From: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>
Sent: Wednesday, December 21, 2022 8:30 AM
To: Peter Perkowski <peter@perkowskilegal.com>; Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; Barghaan, Dennis (USAVAE) <Dennis.Barghaan@usdoj.gov>
Cc: 'Harding, John' <jwharding@winston.com>; 'Bauer, Julie' <jbauer@winston.com>; 'Gailey, Lauren' <lgailey@winston.com>; sommera@gtlaw.com; 'Scott Schoettes' <sschoettes@gmail.com>; 'Kara Ingelhart' <kingelhart@lambdalegal.org>; 'Greg Nevins' <gnevins@lambdalegal.org>
Subject: RE: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565

Peter,

In addition, as we continue to gather information, could you please confirm that you represent the below individuals and have their permission for us to share information about them with you? I know you said you represented them during our previous meet and confer, but we would appreciate it if you could confirm that your representation continues and that you have permission for us to share their information.

Best,
Josh

From: Abbuhl, Joshua (CIV)
Sent: Wednesday, December 21, 2022 11:14 AM
To: Peter Perkowski <peter@perkowskilegal.com>; Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; Barghaan, Dennis (USAVAE) <DBarghaan@usa.doj.gov>
Cc: 'Harding, John' <jwharding@winston.com>; 'Bauer, Julie' <jbauer@winston.com>; 'Gailey, Lauren' <lgailey@winston.com>; sommera@gtlaw.com; 'Scott Schoettes' <sschoettes@gmail.com>; 'Kara Ingelhart' <kingelhart@lambdalegal.org>; 'Greg Nevins' <gnevins@lambdalegal.org>
Subject: RE: [EXTERNAL] Harrison v. Austin, E.D. Va. No 1:18-cv-651; Roe et al. v. Austin, E.D. Va. No. 1:18-cv-1565

Peter,

Confirming receipt of your email. I forwarded it to DoD last night, and we are continuing to work with our clients today concerning your questions. We will respond as soon as we can.

Regards,
Josh

Exhibit 19

Waiver_Redacted

MOD 16 TAB C **CENTCOM Medical Waiver Request**

Patient Name (Last, First): (DELETED) DOB: (DELETED) SSN(Last 4): (DELETED)

Previous Deployments: UKN Destination (country): Iraq Diagnosis (Lay term): History of HIV/Elevated ASC

Age: (DELET Sex: M Grade: UKN Service: UKN Home Station: (DELETED)

Years of Service: UKN Active/Reserve/Guard/Civilian: CIV MOS/Job Description: (DELETED)

Deployment Length: 1 Year Previous Waivers (Y/N): UKN Currently Deployed (Y/N): No

Waiver POC Name/E-mail/Phone: [redacted]

Case Summary (To be completed by provider, including clinical information necessary to make a disposition. See most recent updated MOD 16 and accompanying MOD 16-TAB A for required information. Attach supporting medical documentation (Lack of necessary supporting documentation will result in disapproval):

(DELETED) underwent a pre-deployment medical exam on 6/16/2022. During this exam, it was noted that he has a history of HIV and an elevated ASCVD risk score of 18.1%.

On 8/11/2022, (DELETED) performed a Nuclear Stress Test, Echocardiogram, and Carotid doppler with [redacted] MD. The results of all these tests were normal, with no evidence of ischemia.

On 9/11/2022, (DELETED) followed up with [redacted] MD. [redacted] wrote that (DELETED) HIV is very stable and well-controlled with the medication Biktarvy. His last CD4 in August 2022 was 690 and his viral load was undetectable. (DELETED) employer has confirmed they can accommodate his need for follow up evaluations/labwork.

All of these reports and results are attached for your reference.

I have reviewed the case summary and hereby submit this request.

Signature:_____ **Commander Approval:**_____

CENTCOM Surgeon / Component Surgeon Response

Waiver Approval: ☑ YES ☐ NO

Signature [redacted] **Date:** 3 Oct 2022

APPROVED

Comments:

HIV/AIDS: Iraq imposed HIV/AIDS-related travel restrictions on all visitors and new residents. Travelers should verify their eligibility to travel to Iraq with the Embassy of Iraq before traveling.

HIV and ASCVD meets USCENTCOM requirements, but it is unknown if individual will be allowed in country based on state department information. Given lack of concrete information on ability to enter Iraq, waiver approved.

For Official Use Only: This document may contain information exempt from mandatory disclosure under the Freedom of Information Act (FOIA) of 1986 {Public Law 99-570, 5 USC 552(B)}. This information is also protected by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 {Public Law 104-191} and any implementing regulations. It must be safeguarded from any potential unauthorized disclosure. If you are not the intended recipient, please contact the sender by reply e-mail and permanently delete/destroy all copies of the original message. Unauthorized possession and/or disclosure of protected health information may result in personal liability for civil and federal criminal penalties.

Exhibit 20

April 10 Email

Peter Perkowski

From: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>
Sent: Monday, April 10, 2023 2:27 PM
To: Scott Schoettes
Cc: Berman, Keri L. (CIV); Cooper, Bryce; Kara Ingelhart; Peter Perkowski; Robert Vlasis
Subject: RE: [EXTERNAL] Brief Call re Status of Wilkins, Harrison, and Roe Cases

Hi Scott,

Following up on Wednesday's meet-and-confer, our understanding is that you asked us whether the military would be willing to commit to two things, at which point you would consider not filing a motion to enforce the injunction. Specifically, you requested that in the near future the military should (1) change the language of DODI 6490.07, and (2) change the military's internal procedures for making decisions with respect to whether service members living with HIV can be approved for deployment, commissioning, and possibly other activities. Please let us know if our understanding of your request is incorrect.

The military is in compliance with the injunction (*see* Defendants' letter of Aug. 5, 2022) and declines to commit to making any changes to its internal regulations. To be clear, and as we have discussed, the military has been engaged in an internal policy process to provide additional guidance regarding the Department's change to its HIV policies pursuant to the Secretary of Defense's June 6, 2022 policy memorandum. That process may result in changes that implicate your requests. However, the military is already in full compliance with the injunction notwithstanding that further process, and is not willing to commit to finishing that process with any particular result or on any specific timeframe. In addition, and as you already know, since the June 6 policy memorandum the military has allowed individuals living with HIV to deploy.

In light of the above, Defendants would oppose a motion seeking to enforce the injunction or to order Defendants to show cause why they are not in contempt. If you intend to file the motion, we respectfully request a meet-and-confer to discuss the timing of the motion. For your awareness, both Keri and myself will be out of the office for substantial amounts of time in April, and we would therefore appreciate it if the parties could discuss a briefing schedule that would accommodate everyone's schedule.

Best,
Josh

From: Scott Schoettes <sschoettes@gmail.com>
Sent: Saturday, April 8, 2023 6:30 AM
To: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>
Cc: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; Cooper, Bryce <bcooper@winston.com>; Kara Ingelhart <kingelhart@lambdalegal.org>; Peter Perkowski <peter@perkowskilegal.com>; Robert Vlasis <RVlasis@winston.com>
Subject: Re: [EXTERNAL] Brief Call re Status of Wilkins, Harrison, and Roe Cases

Thanks, Josh. Will expect to hear from you then.

Scott A. Schoettes, Esq. (he/him)
HIV Advocate/Consultant/Attorney
14500 Round Valley Dr.

Exhibit B

Roe Declaration

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

RICHARD ROE, ET AL., Plaintiffs, v. LLOYD J. AUSTIN, ET AL., Defendants.	Civil Action No. 1:18-cv-01565

DECLARATION OF [redacted]

I, [redacted], declare as follows:

1. I am over the age of 18 and competent to make this declaration. I am the plaintiff known as "Richard Roe" in the matter *Roe v. Austin*, No. 1:18-cv-1565, currently pending before this Court. I make this declaration in support of the Plaintiffs' Motion to Enforce the Orders of the Court dated April 6, 2022 (as amended May 10, 2022) and for an Order to Show Cause Why Defendants Should Not Be Held in Contempt.

2. As a result of my HIV-positive status, my Assignment Limitation Code (ALC) in the Air Force is ALC-C2. *See* Form 469-422 for [redacted], dated June 28, 2022 (redacted) (attached hereto as Exhibit 1). This designation on my personnel file defines me as eligible only for assignments within the continental United States (CONUS) with some exceptions if appropriate care is available at an overseas base or non-fixed facility, which means I must secure a medical waiver to deploy overseas. In fact, all Air Force personnel with an assignment limitation code based on a deployment limiting condition (ALC-C1, ALC-C2, and ALC-C3) must secure a medical waiver to deploy, for a permanent change of station (PCS), or even to be placed on temporary duty (TDY). Even though I have met all prerequisites for deployment listed in the Electronic Deployment File (identified by green checkmarks), my Individual Medical

Readiness (IMR) is designated "Red" (designated by an "x"). *See* Electronic Deployment Folder for [redacted], dated March 15, 2023 (attached hereto as Exhibit 2).

3. To secure a medical waiver to deploy, an Airman must first obtain the support of their commanding officer. I have been informed it is also wise—if not crucial—to secure the support of the receiving commanding officer before applying for a medical waiver. Depending on the commanding officers' knowledge regarding HIV, this can be a significant hurdle to overcome. The commanding officers are under no obligation to provide reasons for refusing to support a medical waiver application.

4. The required contents of the "packet" constituting an application for a medical waiver are set forth in Department of Defense Instruction (DODI) 6490.07 and Air Force Instruction (AFI) 48-122. Among other things, an applicant must show that despite their medical condition, they fulfill the general criteria for deployment set forth in DODI 6490.07—and there is a presumption that any servicemember requiring a waiver does not meet these general criteria. In this litigation, the DOD and Air Force fiercely argued that servicemembers living with HIV were not able to fulfill these general criteria for deployment, regardless of their adherence to a medication regimen and the stability of their HIV health. Despite the Court's orders, every Air Force member with an assignment limitation code is still required to submit an application packet overcoming the presumption against them and demonstrating they are able to meet these criteria for deployment.

5. As far as I know, denials of medical waiver requests do not need to be justified or explained to the Airman denied. While it is possible to appeal such a determination, it is often pointless because the deployment date will have passed before an appeal is considered or decided.

6. I have witnessed deployment taskings take place. The first thing senior leaders do is pull the Alpha Roster for the unit, which is essentially an Excel spreadsheet with every unit member's information on it. They then *filter out* anyone that has an assignment limitation code (ALC), an assignment availability code (AAC), a deployment availability code (DAV), or any other code deemed undesirable for deployment such as an unfavorable information file (UIF) or Control Roster designation. The senior leaders then sort the list from longest to shortest "dwell time," which is the number of days not deployed, and begin calling Airman on the list from the top to see if there are any other reasons, they would not be able to be tasked to deploy. If they identify enough eligible Airmen to fulfill the quota on the order that has been sent down, their deployment tasking is complete.

7. I have maintained an undetectable HIV viral load for years (therefore I am also asymptomatic), and this is apparent in my medical records with the Air Force. But I am very concerned that my assignment limitation code will prevent me from deploying when my peers who are not living with HIV deploy. My concerns based on personal knowledge of the deployment tasking process have only been heightened by the stories of others who have been denied deployments shared on the Facebook forum moderated by the Modern Military Association of America ("MMAA"). My understanding is that several asymptomatic HIV-positive servicemembers who have an undetectable viral load have been denied deployment assignments based on their HIV-positive status in various branches of the military.

8. Since this Court's orders became final, I have attempted to have my ALC changed. An ALC-C1 would be better than my current ALC-C2, but to avoid the many inherent pitfalls of the medical waiver process, I believe that no assignment limitation code should be applied to asymptomatic servicemembers with an undetectable viral load. I believe that

continuing to mark our files with any ALC is not treating us the same as other Airmen with chronic manageable conditions that meet the specific criteria for their condition set forth in DODI 6490.07.

Under 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing statements are true and correct. Executed on the date below at Washington, District of Columbia.

Dated: April 10, 2023

[redacted]

Exhibit 1

Roe Form 469-422

This form is governed by the Privacy Act of 1974. (Blanket PAS 1974, Routine Uses) Disclosure of requested information is mandatory. AFI 33-332

DUTY LIMITING CONDITION REPORT

Name (Last, First MI)	RANK	DATE
[redacted]	TSG	06/28/2022

SSAN	MAJCOM / INSTALLATION	Squadron / Unit Of Assignment
[redacted]	Langley AFB (ACC)	438 SUPPLY CHAIN OPS SQ

Squadron E-Mail Address	Duty Telephone:
ashlynd.olivencia@us.af.mil;DANIEL.SCOTT.15@US.AF.MIL;donna.ridgway@us.af.mil;janice.jones.4@us.af.mil;NICHOLAS.SMITH.	☑ DSN 2257023 ☐ Commercial

HEALTH CARE PROVIDER'S MEDICAL RECOMMENDATION FOR THE SQUADRON COMMANDER

☐ DUTY RESTRICTIONS ☑ MOBILITY RESTRICTIONS ☐ 49 / 81

PHYSICAL LIMITATIONS / RESTRICTIONS (DO NOT include medical condition or diagnosis)

These limitations expire 06/28/2023

ALC LIMITATION:
Member may not deploy or PCS without appropriate waiver action within ALC category IAW AFI 41-210, 10-203, and 48-123; refer to AF 422 for ALC stratification.

ALC Code C2(Y): IAW AFI 10-203, member is required to report any change in medical condition to the Primary Care Manager

Release Dates: 31 **37** **81** **MR** 06/28/2023 **DR** **FR**

Name and Grade of Health Care Provider	Signature	Today's Date
JOEL T. HARRIS, Capt, USAF, BSC, PA-C	C=US, O=U.S. Government, OU=DoD, OU=PKI, OU=USAF, CN=HARRIS.JOEL.TYSON.[illegible]	06/28/2022
☐ 31 (ILLNESS OR INJURY WILL BE RESOLVED WITHIN 31-365 DAYS)	☐ 37 (MEDICAL DEFECT/CONDITION REQUIRES MEB OR PEB PROCESSING IAW AFI 41-210)	
Force Health Manager Tara L Dougherty	Signature C=US, O=U.S. Government, OU=DoD, OU=PKI, OU=USAF, CN=DOUGHERTY.TARA.[illegible]	Today's Date 06/29/2022
Profile Officer Review MATTHEW J NEMERO, MAJ, USAF, MC, FS, PRP CMA	Signature C=US, O=U.S. Government, OU=DoD, OU=PKI, OU=USAF, CN=NEMERO.MATTHEW.[illegible]	Today's Date 06/30/2022

SQUADRON COMMANDER'S REVIEW - MOBILITY RESTRICTIONS NOT VALID WITHOUT SIGNATURE

Squadron Commander	Signature	Today's Date
JEFFERSON.ROY.ALLEN.JR.1120546119	C=US, O=U.S. Government, OU=DoD, OU=PKI, OU=USAF, CN=JEFFERSON.ROY.ALLEN.JR.1120546119	08/02/2022

This form is governed by the Privacy Act of 1974. (Blanket PAS 1974, Routine Uses) Disclosure of requested information is mandatory. AFI 33-332

NOTIFICATION OF AIR FORCE MEMBER'S QUALIFICATION STATUS

Name (Last, First MI) [redacted]	RANK TSG	DATE 06/28/2022
SSAN [redacted]	MAJCOM / INSTALLATION Langley AFB (ACC)	Squadron / Unit Of Assignment 438 SUPPLY CHAIN OPS SQ
Squadron E-Mail Address ASHLEY.FALASCO@US.AF.MIL;ashlynd.olivencia@us.af.mil;donna.ridg		Duty Telephone: ☑ DSN 2257023 ☐ Commercial
☐ DENTAL STATUS - UNKNOWN (CLASS 4)		☐ DENTAL TREATMENT - REQUIRED (CLASS 3)

☑ RECOMMENDATION

MEMBER IS CLEARED FOR:

- ☐ Overseas PCS
- ☐ Retraining/Special Duty Assignment
- ☐ Attendance at USAF PME Course
- ☑ Other RTD w/ALC C-2

FOLLOWING AN MEB, MEMBER RETURNED TO DUTY WITH

☑ AN ASSIGNMENT LIMITATION CODE "C" AS DETERMINED BY HQ/AFPC

SEE RECOMMENDED RESTRICTIONS FOR ADDITIONAL COMMENTS

FHM: Check Appropriate C-Code Category Box Below

- ☐ Category C-1
- ☑ Category C-2
- ☐ Category C-3

☐ NOT APPLICABLE

PME, SPECIAL DUTY APPLICATION AND AFSC RETRAINING PHYSICAL PROFILE ASSESSMENT

P	U	L	H	E	S	SAT
-	-	-	-	-	-	-

☐ Initial Flight or Special Operational Duty Physical:

TYPE

Reading Aloud Test ☐ Sat ☐ Unsat

Color Vision Test ☐ Pass ☐ Fail

☑ Other (See Additional FHM Comments)

ADDITIONAL COMMENTS

IAW the DoD policy update to DoDI 6130.02 Vol 2, section 5.23.b.(1) signed on 6 Jun 2022 the member is returned to duty with ALC-C2. Please note the due date for annual RILO. Due 13 Jul 2022.

Waiver for assignment (PCS, TDY, Deployment) is required for all OCONUS locations (except Elmendorf or Hickam) and locations without a fixed intrinsic MTF or TRICARE Network availability per DAFMAN 48-108 para 5.1.1.2.

Name and Grade of Health Care Provider	Signature	Today's Date
JOEL T. HARRIS, Capt, USAF, BSC, PA-C	Aug 12 2022 11:00AM ASIMS	08/12/2022
Force Health Manager MARLANA RYAN, TSG	C=US, O=U.S. Government, OU=DoD, OU=PKI, OU=USAF, CN=RYAN.MARLANA.DEQUAL.1249494558	08/15/2022
Profile Officer Review J. Karen Klingenberger, MPH, MD	C=US, O=U.S. Government, OU=DoD, OU=PKI, OU=CONTRACTOR, CN=KLINGENBERGER.JANE.KAREN.R.1044553047	08/15/2022

AF FORM 422 *SUPERCEDES AF Form 422, APR 89* Computer Generated (ASIMS)

Exhibit 2

Roe Electronic Deployment Folder

PDPT

eDRC

As of January 2019, PDPT data represents a snapshot of personnel, medical, and training information to be used by commanders for planning purposes. Data is scheduled to updated daily and is currently dependent upon connectivity, as well as the entities that own/control the information. Click here to chat with Tech Support.

Member Data

Member	[redacted]	Immunizations	Complete	Currently Deployed	No
AEF Indicator	P3	Immunizations Available	Yes	Member Action Required	No
FIC	Select..	Dental Exam	Complete	Action Needs List	
PASCode	LE1MFK5D	Dental Class	1	DAV Code (Legal)	
Duty Status	PRES FOR DUTY	Lab Work	Current	DAV Code (Physical)	ASGN AVAIL LIMITED CONUS INST W/HOSP OR expires 08Aug88
Duty Status - Projected		HRR/PHA	Current	DAV Code (Time)	
Duty Status - Projected Effective Date		Medical Equipment Required	No	DAV Code (Admin)	
Duty Status - Projected Expiration Date		Medical Equipment Issued	Current	Last Updated	15Mar23
Mandatory Training Currency Days (Days Deployed + 30)		IMR Overall Status	Red	IMR GoRed Date	
Security Clearance	SECRET - expires 08Aug32				

Assigned Courses

RAT Category Select..

View Policy

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

NICHOLAS HARRISON, et al., Plaintiffs, v. LLOYD J. AUSTIN, Secretary of Defense, et al., Defendants.	Civil Action No. 1:18-cv-641 (LMB/IDD)
RICHARD ROE, et al., Plaintiffs, v. LLOYD J. AUSTIN, Secretary of Defense, et al., Defendants.	Civil Action No. 1:18-cv-1565 (LMB/IDD)

ORDER

Upon consideration of briefs and arguments related to Plaintiffs Modern Military Association of America and Richard Roe's Motion to Enforce the Court's Orders Dated April 6, 2022 (As Amended May 10, 2022) and for an Order to Show Cause Why Defendants Should Not Be Held in Contempt, the Court finds that Defendants are not in compliance with the permanent injunctions dated April 6, 2022 (as amended May 10, 2022), and it is hereby:

ORDERED, that Defendants must show cause why they should not be held in contempt; that Defendants must take additional actions—including lifting the requirement for asymptomatic HIV-positive service members with an undetectable viral load to obtain a medical waiver to deploy, removing any codes or classifications on personnel files indicating that such a waiver is required, explicitly stating in the listing for HIV in DODI 6490.07 the criteria that

make service members with HIV presumptively deployable under that regulation, and deleting the word "solely" from the regulations pertaining to service members living with HIV—to bring themselves into compliance with the injunctions;

It is further **ORDERED** that within 15 days, Defendants will submit to the Court for review the additional changes to its policies and regulations; that Plaintiffs will have 7 days to comment upon those additional changes before the Court advises as to whether they will bring Defendants into compliance with the injunctions;

It is further **ORDERED** that Defendants will report to the Court every six months for two years: 1) the number of HIV-positive service members with an undetectable viral load who did not deploy at the same time as other members of their units, along with the reason each individual service member did not do so; and 2) the number of HIV-positive service members with an undetectable viral load who were considered for a commission but did not receive one, along with the reason each individual service member did not receive a commission.

Entered this ___ day of _____, 2023.

_____
United States District Judge