UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JOHN VOE,

Plaintiff,

v.

JAMES N. MATTIS, in his official capacity as Secretary of Defense; HEATHER A. WILSON, in her official capacity as Secretary of the Air Force; and the UNITED STATES DEPARTMENT OF DEFENSE,

Defendants.

Case No.: _____

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

1. Plaintiff John Voe,[1] by and through his attorneys, brings this action for declaratory and injunctive relief stemming from his unconstitutional and improper medical discharge from the United States Air Force ("Air Force"). Voe was discharged only because he is living with the human immunodeficiency virus ("HIV"), despite repeatedly being found medically fit for duty since his diagnosis.

STATEMENT OF THE CASE

2. Members of the U.S. Armed Forces embody the best of the American spirit. They sacrifice to serve and defend us for love of country and community. In return, our nation has made sacred promises to provide medical care for them and to treat them with the respect and dignity they deserve. Our military treats service members' wounds and illnesses and, when able, they

[1] Plaintiff's motion to proceed here under a pseudonym has been filed contemporaneously herewith.

continue to serve. When military physicians determine that service members are unfit for duty and unable to continue serving, they are afforded a process to be medically separated or retired.

3. Unfortunately, at least one type of illness has led certain officials in the military to surrender that promise. Asymptomatic HIV has been diagnosed in a significant number of active duty service members. Contrary to widespread misunderstandings about HIV, a new diagnosis does not have the same ramifications it did when HIV first entered the public consciousness. For most people living with HIV, medication renders their HIV inconsequential to their daily lives. Those who adhere to these medications have no symptoms or significant effects on their immune systems and reach a suppressed viral load, making it impossible to transmit HIV. With access to basic health care, those found medically fit for duty continue to contribute meaningfully to the military and to their country.

4. Recognizing the important contributions of these service members, the Department of Defense ("DoD") has clear policies and regulations, dating back to 1988, to retain those who are diagnosed with HIV while on active duty. According to DoD publications, from 2011 to 2016, the Air Force diagnosed 181 airmen with HIV; in 2017, 119 of those airmen—more than 65%—were still serving. In 2011, the U.S. Army counted 480 soldiers with HIV serving on active duty, with some serving for more than 20 years after they were diagnosed. Recognizing the contributions of service members living with HIV, the U.S. Navy now evaluates service members on a case-by-case basis for some overseas and operational assignments, including on ships, submarines, and aircraft carriers. And, as of late 2017, the Air Force has allowed at least 13 airmen living with HIV to serve overseas and support vital missions. Indisputably, these service members are fit for duty, have needed skills to contribute, and are able to manage their HIV without it affecting their duties.

5. Sadly, not all decision makers in the military have caught up to modern science. This case highlights one such example, in which certain Air Force personnel ignored the recommendations of their own medical officers and operational commanders when they wrongly separated a cadet who was deemed medically fit to serve.

6. Plaintiff John Voe enlisted in the Air Force in 2009. He dreamed of being an officer, and after much hard work, dedication, and serving with distinction for years, he secured a coveted appointment to the U.S. Air Force Academy ("USAFA") in 2012.

7. While on active duty after enrolling at the USAFA, Voe was diagnosed with HIV during a routine military medical examination mid-way through his second year. Though the diagnosis at first seemed a setback, Voe reaffirmed his commitment to country and to service. He learned that the condition was manageable and it would not interfere with his duties or his ability to serve as an officer.

8. In accordance with military regulations and procedures, Voe was evaluated by military medical professionals to determine whether he was medically fit to serve. He was found fit for duty and received a waiver as to his HIV diagnosis to return to duty and to continue his education at the USAFA. Over time, he would be re-evaluated twice more for routine follow-ups, each time being found medically fit for duty.

9. Air Force officials understood that Voe would have been able to continue to serve if he had been diagnosed with HIV as either (i) an enlisted member who wanted to remain enlisted; or (ii) a commissioned officer. But because Voe was enrolled in the USAFA as a cadet when he received his HIV diagnosis, Voe was denied his commission upon graduation and kicked out of the military altogether without being afforded the discharge evaluation procedures required by the DoD.

10. The Air Force's actions were not just contrary to military regulations relating to the treatment of active duty service members with HIV. To the extent the Air Force followed any outdated policies pertaining to HIV, its actions violate the Administrative Procedures Act and were unconstitutional. Specifically, policies and practices implemented by the DoD and Air Force that single out and treat Voe—and others like him living with HIV—differently from other service members are arbitrary, capricious, contrary to law, an abuse of discretion, and a violation of Voe's right of equal protection.

11. At best, Air Force policies singling out service members living with HIV for starkly different treatment are an unfortunate vestige of a time when HIV was untreatable and invariably fatal—an anachronism whose justifications no longer comport with modern medical science. Whether these policies reflected animus at the time they originally were created or not, they now constitute outright discrimination. When faced with other conditions or illnesses, each service member is given due consideration based on his or her circumstances and condition. By contrast, when Voe attempted to commission as an officer while living with HIV, he faced an ill-informed, categorical bar banning him from continuing his service.

12. The Air Force and the DoD have neglected their duty to take care of their own. The justifications used to discharge a medically fit service member such as Voe—and to treat him unequally solely because he is living with HIV—are neither supported by law or evidence. By establishing the illegality of Defendants' conduct and reinstating Voe's commission as an officer, this case seeks to correct that injustice and to prevent others from enduring the same mistreatment.

JURISDICTION AND VENUE

13. This Court has jurisdiction over the subject matter of this action under 28 U.S.C. §§ 1331, 1343, and 2201–02. This case poses federal questions that arise primarily from the U.S.

Constitution; the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 701–706; and other federal statutes, including 10 U.S.C. §§ 101, 1203, 1217, and 8075.

14. Venue is proper in this district under 28 U.S.C. § 1391(b)(2) and (e)(1). A substantial part of the events and omissions giving rise to these claims occurred in this District. Additionally, the named Defendants are officers of the United States who conduct a significant amount of their official duties in this District.

THE PARTIES

A. Plaintiff

15. Plaintiff Voe is an honorably discharged veteran who served on active duty in the Air Force—first as an enlisted service member and later as a cadet at the USAFA, graduating in June 2016.

16. Voe proceeds under a pseudonym not only for reasons of medical privacy but also because of the stigma, discrimination, and common misunderstandings associated with HIV.

B. Defendants

17. Defendant James N. Mattis is the Secretary of the Department of Defense. He leads the DoD and is responsible for the administration and enforcement of the challenged policies and practices.

18. Defendant Heather A. Wilson is the Secretary of the U.S. Air Force. She is the leader of the Department of the Air Force and responsible for its regulations and the actions taken against Voe.

19. The Department of Defense is a department within the executive branch of the U.S. government responsible for coordinating and supervising all agencies and functions of the government concerned directly with the U.S. Armed Forces. Under the direction of Secretary

Mattis, DoD is also responsible for administration and enforcement of the challenged policies and regulations.

20. All Defendants are sued in their official capacities and each count below is alleged against all Defendants.

BACKGROUND

A. Statutory and Regulatory Background

21. In addition to the Code of Federal Regulations ("C.F.R."), two sets of regulations are relevant to active duty service members, including cadets, who are diagnosed with HIV: Department of Defense instructions ("DoDIs") and Air Force instructions ("AFIs").[2] Excerpts of these regulations in effect at the time of the events described herein are appended to this Complaint:

- Exhibit A: DoDI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services (Apr. 28, 2010) (the "Medical Entry Standards DoDI")
- Exhibit B: AFI 48-123, Medical Examinations and Standards (Nov. 5, 2013) (the "Medical Standards AFI")
- Exhibit C: AFI 36-3504, Disenrollment of United States Air Force Academy Cadets (July 9, 2013) (the "Disenrollment AFI")
- Exhibit D: DoDI 6485.01, Human Immunodeficiency Virus (HIV) in Military Service Members (June 7, 2013) (the "HIV DoDI")
- Exhibit E: AFI 44-178, Human Immunodeficiency Virus Program (Mar. 4, 2014, certified current June 28, 2016) (the "HIV AFI")

[2] Current DoDIs and other DoD regulations and policies may be viewed at http://www.esd.whs.mil/DD/. Current AFIs and similar regulations or policies may be viewed at http://www.e-publishing.af.mil/.

B. Treatment of HIV

22. The landscape of HIV treatment and prevention, the ramifications of an HIV diagnosis, and the prognosis for people living with HIV have all changed dramatically since the virus was first identified in the 1980s.

23. In 1996, the advent of new antiretroviral medications to prevent the virus from replicating transformed the landscape of HIV treatment and prevention and radically shifted health outcomes for people living with HIV.

24. The effectiveness of these antiretroviral medications is measured by the reduction in the number of copies of the virus in a milliliter of a person's blood, which is referred to as the "viral load." While a person in the acute or secondary stage of infection could have a viral load of one million or more, a person in successful treatment will have a viral load of less than 200, which is considered "virally suppressed," or a viral load of less than 48-50, which is referred to as an "undetectable" viral load.

25. With adherence to these medications, people living with HIV are restored to good health. Patients with an AIDS diagnosis were literally brought back from the brink of death through antiretroviral combination therapy. Over time, researchers and clinicians were able to refine the use of these medications to make treatment adherence easier and health outcomes even better. Though the side effects of the initial antiretroviral drugs were generally tolerable, researchers developed new medications that had few or no discernible side effects for most people. The standard of care shifted to starting treatment with antiretroviral drugs almost immediately after diagnosis—a recognition that the benefits of treatment far outweighed any negative consequences of being on these medications.

26. Today, though still incurable, HIV is a chronic, manageable condition rather than the terminal diagnosis it once was. In fact, a 25-year-old diagnosed in a timely fashion and provided appropriate treatment has very near the same life expectancy as a 25-year-old who does not have HIV.

27. Furthermore, medical researchers have now established that a person with a suppressed viral load is incapable of transmitting HIV. Contrary to popular belief, even without viral suppression, HIV is not easily transmitted. The Centers for Disease Control and Prevention ("CDC") estimates that, in the absence of treatment or other preventive measures, such as condom use, the risk of HIV transmission through a single act of receptive anal sex—the riskiest sexual activity—is approximately 1.38%.[3] The per-act risk of transmission for other sexual activities is between zero and .08%. However, *with adherence to HIV medications and the resulting viral suppression, the risk of transmission is essentially zero for any sexual activity*.[4] Antiretroviral treatment therefore not only dramatically improves personal health outcomes, but also improves public health outcomes by reducing transmission and the number of new cases.

28. Transmission of HIV is extremely rare outside of the context of sexual activity, sharing of injection drug equipment, blood transfusion, needle sticks, or perinatal exposure (including breastfeeding). For all other activities—including biting, spitting, and throwing of body fluids—the CDC characterizes the risk as "negligible" and further states that "HIV transmission

[3] *See* Centers for Disease Control and Prevention, *HIV Risk Behaviors: Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act*, www.cdc.gov/hiv/risks/estimates/riskbehaviors.html (last updated Dec. 4, 2015).

[4] *See* Centers for Disease Control and Prevention, *Treatment as Prevention*, www.cdc.gov/hiv/risk/art/ (last updated May 7, 2018).

through these exposure routes is technically possible but unlikely and not well documented."[5] The theoretical possibility of HIV transmission in these other contexts is eliminated entirely by adherence to medications and the viral suppression that results.

29. Despite the tremendous breakthroughs in the treatment and prevention of HIV, people living with HIV continue to be subjected to stigma, ostracization, and discrimination rooted in misconceptions, fear, and ignorance that is deeply rooted in the psyche of the American public.

C. Voe's Discharge from the Air Force

30. On January 13, 2009, Voe enlisted in the Air Force for a term of six years. He subsequently earned the position of Space System Operations Journeyman.

31. On July 13, 2011, Voe was promoted to the grade of E-4, Senior Airman, the grade he retained until his honorable discharge.

32. From June 28, 2012, to January 12, 2015, Voe was a member of the Air Force in enlisted status and on active duty while a cadet at the USAFA. (*See* 10 U.S.C. § 516.) U.S. service academy cadets are service members on active duty. *See, e.g.*, 10 U.S.C. § 101(d)(1) ("The term 'active duty' . . . includes . . . attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned.").

33. On February 28, 2014, while at the USAFA, Voe was diagnosed with HIV after a routine physical examination. A military medical evaluation board ("MEB") was subsequently convened to assess Voe's medical qualification for continued service, in accordance with the Disenrollment AFI (Ex. C).

[5] Centers for Disease Control and Prevention, *HIV Risk Behaviors: Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act*, www.cdc.gov/hiv/risks/estimates/riskbehaviors.html (last updated Dec. 4, 2015).

34. On June 2, 2014, the MEB issued a Return to Duty determination, allowing then-cadet Voe to continue to serve in the military.

35. On June 9, 2014, Voe's immediate commanding officer held a meeting with other USAFA staff members to determine the "way ahead" for Voe, presenting a PowerPoint deck entitled the "way ahead" and noting divergent standards for *accession* of individuals living with HIV into the military and *retention* of individuals living with HIV already in the military. Accession standards precluded individuals living with HIV from appointment, enlistment, or induction into the military, whereas retention standards permitted enlisted and commissioned officers diagnosed with HIV on active duty to remain if found medically fit. *See* Medical Entry Standards DoDI, Ex. A ¶ 4(a)–(c), at p. 2, Encl. 4 ¶ 1, at p. 10, Encl. 4 ¶ 24(b), at p. 38; HIV DoDI, Ex. D Encl. 3 ¶ 2(c), at p. 7; HIV AFI, Ex. E, Attach. 9 ¶ A9.1, at p. 36.

36. USAFA staff officers were confused about the applicable standard because, as stated in the PowerPoint, "there was no verbiage specific to prior-enlisted cadets," which Voe was.

37. On November 3, 2015, Voe received a medical waiver for HIV from Lt. Gen. Michelle D. Johnson, the superintendent of the USAFA, to continue his service at the USAFA.

38. In or around August 2014, during the beginning of his third year at the USAFA, Voe was offered and took a "commitment oath," vowing to serve for two additional years at USAFA and five thereafter as an officer. USAFA officials told Voe that he was eligible to take the oath, and they did not inform him of any possibility that he might not be allowed to commission.

39. Voe participated in the same commitment ceremony as all of the other cadets in his class. He also received the same commitment packet, including a letter from the Commander-in-Chief.

40. On January 13, 2015, Voe completed his term of enlistment. Having received a medical waiver and been found medically fit for duty, Voe did not re-enlist, as he was led to believe by officials in the Air Force that he would be able to commission upon graduation from the USAFA.

41. On July 28, 2015, Voe received his second of three return-to-duty authorizations, indicating that he was medically fit to serve.

42. During the fall semester of 2015, certain USAFA officials were led to believe by Air Force officials that Voe would have to be disenrolled in accordance with the HIV AFI (Ex. E). Believing Voe should be permitted to commission, because Voe was (and is) medically fit to perform all of his duties as an officer, USAFA officials began the process of requesting an exception to policy ("ETP") to the HIV DoDI (Ex. D) (which was implemented by the HIV AFI) from the author of that instruction, the Undersecretary of Defense for Personnel and Readiness ("USD/P&R").

43. On September 9, 2015, the director of the Air Force's Medical Evaluation Unit at San Antonio Military Medical Center ("SAMMC") wrote a letter recommending that, in his professional medical opinion, Voe was fit for duty and should be commissioned.

44. On October 1, 2015, the staff Judge Advocate of the USAFA wrote an email expressing doubt that the ETP path was the proper procedure, and instead expressed support for a medical waiver by the USAFA chief medical officer (the "Surgeon General") or delegated authority.

45. In an October 5, 2015 email to the USAFA staff Judge Advocate, the Surgeon General stated that he would grant Voe a medical waiver for HIV.

46. When an ETP application was submitted instead, the Surgeon General maintained his support for Voe to commission in another October 5, 2015 email.

47. Every single officer in Voe's chain of command, from Major to three-star General, including all medical officers responsible for Voe's evaluation and treatment, recommended that Voe be retained and commissioned.

48. In December 2015, a staff summary sheet ("SSS") ETP complete with endorsements, letters, and recommendations was prepared for routing to the USD/P&R as the sole authority to grant an ETP. Every senior officer at the USAFA, including the commanding three-star Superintendent, endorsed the ETP package. Voe viewed the package before submission.

49. On April 12, 2016, the Department of the Air Force issued orders assigning Voe to be a Second Lieutenant and contracting officer at Joint Base Andrews in Maryland, reporting no later than August 6, 2016.

50. Voe graduated from the Air Force Academy on June 2, 2016, with a Bachelor of Science degree.

51. Voe received a certificate of commissioning, a DoD Form 1AF, signed by the Secretary of the Air Force, stating he had been commissioned as a Second Lieutenant in the Regular component of the United States Air Force on June 2, 2016.

52. On or about June 2, 2016, Voe took the same oath of office, required by federal statute, that other cadets took to become officers.

53. On information and belief, Voe was included on a list of persons appointed to the rank of Second Lieutenant, signed by the Secretary of Defense.

54. Notwithstanding other subsequent Air Force administrative requirements that are not prerequisites to holding office, on information and belief, Voe commissioned in the U.S. Air Force as a Second Lieutenant on June 2, 2016.

55. After graduation, however, the Air Force did not recognize Voe as a commissioned Second Lieutenant and held him in cadet status while the ETP was being processed.

56. Voe made numerous inquiries to his commanding officer as to his status and the progress of the ETP. He was not provided with any information responsive to those inquiries.

57. On or about July 22, 2016, Voe was informed through his commanding officer that the ETP package was subject to a delay "caused by a rewrite to the request per staff." Voe was not informed as to the substance of the rewrite, which sections of the ETP were altered, or whether it was rerouted. The commanding officer informed Voe "it was all done by the Air Staff liaison at the Pentagon."

58. On September 14, 2016, while waiting for a determination on the ETP, Voe received his third return-to-duty waiver from military physicians deeming him medically fit to serve.

59. On or about September 21, 2016, Voe met with the USAFA Commander's director of staff, who notified Voe that the Air Force Chief of Staff and Vice Chief of Staff were reviewing the ETP package and would discuss it during an upcoming leadership conference.

60. Neither the Air Force Chief of Staff nor the Vice Chief of Staff were on the original routing sheet for the ETP, nor did they hold any medical expertise or general waiver authority according to applicable regulations.

61. On October 5, 2016, a colonel at USAFA informally notified Voe that the Chief of Staff of the Air Force was recommending that he not be commissioned as an officer.

62. Voe was not informed of the basis or any justification for the Air Force Chief of Staff's action, nor under what authority he was acting.

63. Upon information and belief, the ETP package had been re-routed to either the Chief of Staff of the Air Force or the Secretary of the Air Force, rather than properly sent to the USD/P&R for approval or denial.

64. On October 13, 2016, Voe was informed by the USAFA's staff Judge Advocate and other officers from the USAFA that the Secretary of the Air Force denied the ETP request.

65. On October 26, 2016, Deputy Assistant Secretary of the Air Force for Force Management Integration, Jeffrey R. Mayo, wrote a letter to the USAFA commander stating that the Secretary of the Air Force disapproved of Voe's ETP request on September 28, 2016, and approved of taking action to separate and discharge him.

66. On November 1, 2016, Voe was summarily discharged from the Air Force.

67. Voe's Certificate of Discharge ("DD-214") characterizes the discharge as honorable and offers "Secretarial Authority" as the narrative reason for separation. AFI 36-3504 (Ex. C, the Disenrollment AFI) is listed as the authority for Voe's separation on his DD-214.

68. If properly assessed under the Disenrollment AFI, Voe met the standards for continued service and commissioning by virtue of either a return-to-duty determination or the granting of a waiver by the chief medical officer of USAFA, the Surgeon General, as directed by that regulation and the Medical Standards AFI (Ex. B).

69. Voe's DD-214 also originally listed him as a commissioned Second Lieutenant. An administrative correction subsequently was issued to amend his rank to "AF Cadet."

70. Voe's DD-214 now indicates that he did not become an officer and was removed from the Air Force Academy shortly after graduation. The only two logical conclusions to be

drawn from Voe's DD-214 are either that the Air Force found Voe unfit to serve or that some other unusual circumstance or problem required his separation from service.

71. The basis for Voe's discharge was that he was not medically fit for duty. However, a discharge based on medical unfitness must be processed through the disability evaluation system ("DES"). (Ex. B, Medical Standards AFI ¶ 5.2, at p. 24.) When Voe was discharged, he did not undergo any such processing, despite acquiring HIV while on active duty.

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72. Despite seemingly complex regulations, this case is simple: Military medical professionals, who have the requisite knowledge, expertise, and judgment, should determine whether a person is medically fit to serve. And no predetermined biases or stigma-based categorical bans should interfere. The Constitution, military regulations, and equitable principles demand nothing less.

73. Moreover, Voe passed medical evaluations and was found fit for duty three times after testing positive for HIV. According to DoD and Air Force regulations, Voe should have been and/or was: (a) granted a medical waiver and retained as an officer; or (b) retained after being processed through the DES and returned to duty as an officer (and categorized in the "retention" standard for all applicable regulations); and/or (c) retained because the sole person with the authority to grant him a waiver—the chief medical officer of the USAFA—indicated he would grant a waiver and advocated that Voe be commissioned as an officer.

74. If it is determined that Air Force and DoD officials followed proper procedures and did not act in an arbitrary or capricious manner in denying Voe his commission, the regulations to which Voe was subjected are otherwise contrary to law and a violation of equal protection. They should be invalidated. Under retention standards (including those already issued in the HIV

DoDI), setting criteria for HIV similar to those for other chronic, manageable conditions, Voe would be commissioned as an officer.

CLAIMS FOR RELIEF

COUNT I

Violation of the Administrative Procedure Act (APA) as to Plaintiff's Discharge

75. All prior paragraphs are incorporated as if fully set forth herein.

76. The Air Force failed to abide by its own regulations and governing statutes in the process of summarily discharging Plaintiff.

77. If the procedures set forth in the regulation cited as the separation authority for Plaintiff, AFI 36-3504, had been followed, Plaintiff would have been retained and commissioned, as discussed above.

78. Title 32, part 66 of the Code of Federal Regulations and the Medical Entry Standards DoDI (Ex. A, DoDI 6130.03, Encl. 2 ¶ 3, at p. 7) granted medical waiver authority to the service secretary, who by the Medical Standards AFI delegated that authority to the chief medical officer of the U.S. Air Force Academy (Ex. B, AFI 48-123, Attach. 2, at p. 78), who stated he would grant a waiver to Voe to continue at the Academy and to serve as an officer. The service secretary provided no explanation or rationale for why the appropriate regulations were not followed. Plaintiff should have been retained and commissioned under these regulations.

79. If the retention standards for active duty members had been applied to Plaintiff, he would have been retained in the military, according to either the Medical Entry Standards DoDI (Ex. A), the HIV DoDI (Ex. D), or the HIV AFI (Ex. E).

80. If the accession standards had been applied to Plaintiff, he would have been retained and allowed to serve as an officer, because he was granted a waiver by the Surgeon General and/or as part of an MEB process and was found fit for duty.

81. Voe's completed ETP was not properly routed to the USD/P&R as the sole authority to grant an ETP pursuant to the relevant regulations, but rather was improperly intercepted by the Air Force Chief of Staff, leading to his discharge.

82. Pursuant to the Medical Standards AFI, a cadet found medically unfit for duty must go through DES processing in accordance with federal statute and regulations. (Ex. B, AFI 48-123 ¶ 5.2.1.1, at p. 24). In accordance with the Disenrollment AFI, the only path to discharge a cadet with medical issues is to conduct a DES, which consists of a MEB process and, if found unfit there, a referral to a Physical Evaluation Board ("PEB") to determine final fitness, disability, or separation. (Ex. C, AFI 36-3504 ¶ 8, at p. 5). The Air Force denied Plaintiff the proper DES process.

83. Through the actions and omissions above, Defendants violated the APA.

COUNT II

Violation of the Administrative Procedure Act (APA)
as to AFI 44-178

84. All prior paragraphs are incorporated as if fully set forth herein.

85. Plaintiff has no adequate or available administrative remedy; in the alternative, any effort to obtain an administrative remedy would be futile.

86. The parts of the HIV AFI (Ex. E) that direct active duty cadets and officer candidates to be summarily disenrolled or not afforded a disability evaluation process are proscribed by the APA and should be declared unlawful because they are arbitrary, capricious, not in accordance with law, and an abuse of discretion.

87. The parts of the HIV AFI that categorically bar USAFA cadets or other officer candidates with HIV from being commissioned as officers are arbitrary, capricious, not in accordance with law, and an abuse of discretion.

88. The HIV AFI is based on outdated thinking that does not comport with the current state of HIV medical science.

89. The parts of the HIV AFI that categorically bar USAFA cadets or other officer candidates with HIV from participating in a commissioning program or from being commissioned as officers conflict with several federal statutes and with other DoD and Air Force regulations, including:

(a) Attachment 9 of AFI 44-178 (Human Immunodeficiency Virus Program), which directs retention for active duty service members living with HIV (Ex. E, AFI 44-178, Attach. 9 ¶ A9.1 at p. 36);

(b) 10 U.S.C. § 101(d)(1), 10 U.S.C. § 8075, and cases such as *Doe v. Hagenbeck*, 870 F.3d 36, 45 (2d Cir. 2017), and *Doe 1 v. Trump*, No. 17-5267, 2017 WL 6553389, at *1 (D.C. Cir. Dec. 22, 2017), which hold that academy cadets are active duty service members;

(c) DoDI 6485.01 (Human Immunodeficiency Virus (HIV) in Military Service Members), which states that active duty members are to be retained if they clear medical evaluations (Ex. D, DoDI 6485.01, Encl. 3 ¶ 2(c), at p. 7);

(d) 10 U.S.C. ch. 61 (Retirement or Separation for Physical Disability), which states that medical separation and DES processing applies to service academy cadets and outlines the process for medical separations;

(e) DoDI 1332.18 (Physical Disability Evaluation), which is the DoD regulation referenced in DoDI 6485.01 and necessarily contemplates waiver, and which implements chapter 61 of title 10 for the Department of Defense;

(f) AFI 36-3212 (Physical Evaluation for Retention, Retirement, and Separation), which implements the DES process from federal statute and the parent DoDI 1332.18;

(g) 32 C.F.R. pt. 66 (Qualification Standards for Enlistment, Appointment, and Induction), which states that the service secretary is the waiver authority for a medical standard;

(h) DoDI 6130.03 (Medical Standards for Appointment, Enlistment, or Induction in the Military Services), which states that the service secretary is the waiver authority for a medical standard (Ex. A, DoDI 6130.03, Encl. 2 ¶ 3(b), at p. 7);

(i) AFI 48-123 (Medical Examinations and Standards), which delegates waiver authority from the Secretary of the Air Force to the USAFA chief medical officer (USAFA/SG), and states that if a cadet receives a waiver from the accession medical standards, the retention medical standards apply (Ex. B, AFI 48-123, Attach. 2, Table A.2.1, at pp. 77–78; Ex. B, AFI 48-123 ¶ 5.2.1.1, at p. 24); and

(j) AFI 36-3504 (Disenrollment of United States Air Force Academy Cadets), which states that AFI 48-123 controls the fitness for duty or medical discharge of USAFA cadets (Ex. C, AFI 36-3504 ¶ 8, at p. 5).

90. The likely origin of the inconsistency presented by parts of the HIV AFI that categorically bar USAFA cadets or other officer candidates with HIV from being commissioned can be traced to the Air Force's failure to update the HIV AFI at the same time the DoD replaced

its corresponding HIV DoDI regulation in 2006. As a result, Attachment 2 provides an outdated and inconsistent section of the HIV AFI that was not properly updated, fails to comply with statutes directing a disability evaluation for all cadets who incur a disabling condition in the line of duty, and is inconsistent with subsequent regulations.

91. For the reasons above, certain parts of the HIV AFI are arbitrary, capricious, not in accordance with law, an abuse of discretion, and contrary to the APA.

92. Through the actions and omissions above, Defendants violated the APA.

COUNT III

Violation of the Administrative Procedure Act (APA)
as to DoDI 6485.01

93. All prior paragraphs are incorporated as if fully set forth herein.

94. Plaintiff has no adequate or available administrative remedy; in the alternative, any effort to obtain an administrative remedy would be futile.

95. Applying the HIV DoDI (Ex. D) to bar service academy cadets or other officer candidates with HIV from participating in a commissioning program or from being commissioned as officers is arbitrary, capricious, not in accordance with law, an abuse of discretion, and contrary to the APA.

96. Applying the HIV DoDI to prevent the secretary of each armed service or their designees to determine waiverability of the medical standards she has set for fitness to serve is contrary to regulation and statute, and otherwise arbitrary and capricious and an abuse of discretion, all contrary to the APA.

97. The original publication of the DoD regulation prohibiting people with HIV from joining the service in any capacity, and prohibiting service members with HIV from becoming officers, did not establish that the DoD had examined the relevant data and did not articulate a

rational connection between the facts and the policy choices made. As such, that DoDI and any subsequent continuation of those prohibitions in the Code of Federal Regulations, in DoD directives, instructions, or other regulations, or in service-specific directives, instructions, or regulations, is arbitrary, capricious, not in accordance of law, an abuse of discretion, and violative of the APA.

98. The HIV DoDI was required to have been both published in the Federal Register and put through notice and comment. It was not. Accordingly, the Court should vacate the regulation based on the procedural violation.

99. Additionally, or alternatively, because the HIV DoDI was a substantive or legislative rule, this Court should vacate it as unlawful based on either a procedural violation of the APA or a procedural violation of the DoD's own regulations.

100. If the DoDI is considered interpretative, the policy on excluding service members or civilians with HIV from becoming officers is arbitrary and capricious, not in accordance with law, and contrary to the APA.

101. Through the actions and omissions above, Defendants violated the APA.

COUNT IV

Violation of Procedural Due Process Under the Fifth Amendment

102. All prior paragraphs are incorporated as if fully set forth herein.

103. Plaintiff was discharged purportedly because he was medically unfit for duty due to a medical condition (HIV) he acquired while on active duty. While Plaintiff does not agree that he was medically unfit, the Air Force's discharge entitled Plaintiff to a DES process in accordance with Air Force and DoD regulations and chapter 61 of title 10 of the U.S. Code. Plaintiff has a property right in the benefits to which he is entitled as a service member who acquired, while on active duty, a condition the military deemed disabling.

104. The actions taken by the Air Force and DoD placed a stigma or purported disability on Plaintiff that led to a change in Plaintiff's status and foreclosed his freedom to take advantage of employment opportunities and by broadly precluding him from continuing in his chosen career. Moreover, Defendants' actions are more likely to result in the forced disclosure of Plaintiff's HIV status in order to explain the discharge on his record. As a result, the Defendants deprived Plaintiff of a liberty interest.

105. Plaintiff was not afforded the process due, such as processing through the DES. He was not given the opportunity to dispute to the proper authority through evidence, testimony, and a hearing that he was—and is—medically fit for service and fit for service as an officer.

106. Plaintiff had, in fact, been determined by the relevant medical authorities to be medically fit for duty as an officer when the Air Force and DoD precluded him from serving further on the false basis that he was not medically fit for service as an officer. That false determination caused Plaintiff's inability to continue his service as an officer and directly caused his discharge.

107. The assumption that Plaintiff was not medically fit for duty was not only spread through official action internally but was also the underlying reason for discharge. If a prospective external employer were to ask why Plaintiff was abruptly discharged from the Air Force shortly after graduating from the Academy, an unusual and therefore suspicious occurrence, Plaintiff would be compelled to answer truthfully. The defamatory rationale for his separation affected Plaintiff's reputation and is affecting his employment prospects, depriving him of a liberty interest.

108. If valid (which Plaintiff disputes), the regulations or policies of the Air Force and the DoD that prohibit enlisted persons such as Plaintiff from pursuing their chosen careers as officers based solely on their HIV status, place upon them a false stigma that similarly deprives them of a liberty interest. Instead of being afforded a medical evaluation and the process necessary

to determine whether they are medically fit for duty, they are automatically and arbitrarily categorized as medically unfit and excluded from a range of employment opportunities as officers, despite hundreds of others with the same condition being allowed to continue to serve as officers in a multitude of positions.

109. Through the actions and omissions above, Defendants have violated the Due Process Clause of the Fifth Amendment.

COUNT V

Equitable Estoppel

110. All prior paragraphs are incorporated as if fully set forth herein.

111. Through its conduct and statements, Defendants made a definite representation to Plaintiff that he was medically fit for duty as a cadet and to commission as an officer.

112. In reasonable reliance on the military's continued representations and assertions, Plaintiff took an oath and committed to further service at risk of substantial financial penalty—to wit, repayment of approximately $400,000 in education expenses—if he did not commission. He also made the decision to forgo other opportunities to find other forms of employment in reliance on these assertions. He also decided not to re-enlist.

113. Plaintiff was not informed of any medical-based jeopardy to his ability to commission until well after he took a commitment oath and began his third year at the Academy, despite the military officials' knowledge that his HIV status would jeopardize his ability to commission.

114. After military doctors found Plaintiff fit for duty, as well as fit to serve as an officer, and decided to give him a medical waiver to allow him to commission, the Air Force ultimately discharged Plaintiff on the basis that he was not medically fit.

115. Defendants therefore engaged in affirmative misconduct, because they behaved in ways that caused an egregiously unfair result, and Voe reasonably relied on such conduct to his detriment.

116. Accordingly, based on equitable principles, Defendants should be estopped from basing Plaintiff's disenrollment and discharge on the assertion that he was not medically fit.

117. Plaintiff is entitled to a declaration that Defendants are estopped from discharging him based on his HIV status.

COUNT VI

Declaratory Judgment

118. All prior paragraphs are incorporated as if fully set forth herein.

119. The Declaratory Judgment Act, 28 U.S.C. § 2201, allows the Court to "declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought."

120. Despite subsequent actions taken by military officials indicating the contrary, Plaintiff commissioned as an officer in the Air Force upon graduation from the USAFA on June 2, 2016.

121. The Department of Defense or the Air Force does not have authority to revoke or not recognize a completed commission.

122. Plaintiff is entitled to a declaratory judgment that he commissioned as an officer in the Air Force.

COUNT VII

Violation of Equal Protection Under the Fifth Amendment's Due Process Clause (Based on HIV Status)

123. The Fifth Amendment to the United States Constitution provides that no person shall be deprived of life, liberty, or property without due process of law. The Due Process Clause includes within it a prohibition against the denial of equal protection by the federal government, its agencies, its officials, or its employees.

124. Defendants' accession policies discriminate impermissibly against people living with HIV both on their face and as-applied by barring people living with HIV from enlistment in the military and appointment as officers in the military based solely on their HIV status.

125. Defendants routinely permit similarly situated individuals who are not HIV-positive, including but not limited to people with comparable chronic, manageable conditions, to enlist in the military and to commission as officers, including for positions such as a contracting officer in the Air Force.

126. Defendants have refused to grant Plaintiff John Voe a commission as an officer serving as a Second Lieutenant and contracting officer in the Air Force based solely on his HIV status.

127. Although some individuals living with HIV may qualify under certain statutory schemes as having a disability or as being disabled, discrimination targeting people based on their HIV-positive status warrants a more rigorous degree of scrutiny than was described in *City of Cleburne, Texas v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985).

128. Government discrimination against individuals living with HIV bears all the indicia of a suspect classification requiring heightened scrutiny by the courts.

a. People living with HIV have suffered through a unique history of misinformation, stigma and discrimination for decades, and continue to suffer such discrimination to this day.

b. People living with HIV are a discrete and insular group and lack the political power to protect their rights through the legislative process. A small minority of the overall population is currently living with HIV. People living with HIV fear to disclose their status, rarely choose to live openly with HIV, and continue to lack representation at any level of the federal government. For the first decade of the HIV epidemic, the needs of people living with and at higher risk for HIV were ignored and/or not adequately resourced by federal, state, and local governments. Even today, many people living with HIV do not have access to care, and there are aspects of the criminal law that unfairly single out and discriminate against people living with HIV.

c. Particularly in light of dramatic medical advances—the benefits of which have only recently been fully understood and documented—a person's HIV status bears no relation to that person's ability to contribute to society.

d. Even with medical treatment rendering their viral load undetectable, a person cannot change their HIV status. While HIV is treatable and manageable, it is not curable. There is no available course of treatment that a person could undergo to change their status as a condition of equal treatment.

129. Defendants' disparate treatment of Plaintiff and other individuals living with HIV deprives them of their right to equal dignity and stigmatizes them as second-class citizens in violation of equal protection guarantees.

130. There is no longer a valid purpose for this disparate treatment, and neither is the classification at issue—HIV status—adequately tailored in service of any governmental interest. This disparate treatment is not even rationally related to a legitimate governmental interest, let alone is there an important or compelling governmental interest to which these policies are substantially related or narrowly tailored. Thus, the enlistment ban and service restrictions cannot withstand any form of scrutiny and are invalid.

REQUEST FOR RELIEF

WHEREFORE, Plaintiff respectfully requests that this Court:

A. Enter a declaratory judgment, pursuant to 28 U.S.C. § 2201, that Plaintiff's discharge was arbitrary, capricious, an abuse of discretion, and not in accordance with law;

B. Enter a declaratory judgment, pursuant to 28 U.S.C. § 2201, that Plaintiff's discharge was unconstitutional;

C. Enter a declaratory judgment, pursuant to 28 U.S.C. § 2201, that Plaintiff commissioned as an officer in the Air Force;

D. Vacate and set aside the discharge;

E. Enter an injunction directing the Department of Defense to reinstate Plaintiff as a Second Lieutenant, or in the alternative, directing the Air Force to reinstate Plaintiff as a graduated cadet at the U.S. Air Force Academy;

F. Enjoin the Air Force from using AFI 44-178 to bar or to disenroll from a commissioning program, or discharge from the service, any person diagnosed with HIV while on active duty, including U.S. Air Force Academy Cadets;

G. Enjoin the Department of Defense from allowing or using DoDI 6485.01, or any service-specific regulation that derived from any version of DoDI 6485.01, to bar, to

disenroll from an officer program, or to discharge from the military, any service academy or officer training applicant or member diagnosed with HIV while on active duty;

H. Issue an injunction directing that HIV-positive service members, including service academy cadets or midshipmen, not found medically fit for duty and not otherwise receiving a waiver or exception to policy, undergo DES processing in the same manner as those with any other illness or injury;

I. Award Plaintiff reasonable costs and attorneys' fees;

J. Award such further relief as this Court deems appropriate.

Dated: May 30, 2018

Respectfully submitted,

/s/ Peter E. Perkowski

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* *Pro hac vice* application forthcoming
** Application for admission or renewal filed with the clerk of this Court

EXHIBIT A

Department of Defense

INSTRUCTION

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

USD(P&R)

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

References: See Enclosure 1

1. PURPOSE. This Instruction:

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

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

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

2. APPLICABILITY. This Instruction applies to:

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

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

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

3. DEFINITIONS. See Glossary.

4. POLICY. It is DoD policy to:

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

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

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

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

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

(3) Medically capable of satisfactorily completing required training.

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

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

5. RESPONSIBILITIES. See Enclosure 2.

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

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

8. EFFECTIVE DATE. This Instruction is effective immediately.

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

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

Glossary

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ENCLOSURE 1

REFERENCES

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

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

ENCLOSURE 2

RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ENCLOSURE 3

MEDPERS

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

2. MEDPERS shall:

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

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

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

ENCLOSURE 4

MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION

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

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

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

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

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

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

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

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

h. All individuals being inducted into the Military Services.

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

3. HEAD

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

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

4. EYES

a. Lids

(1) Current symptomatic blepharitis (373.0x).

(2) Current blepharospasm (333.81).

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

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

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

b. Conjunctiva

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

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

c. Cornea

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

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

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

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

(b) Pre-surgical astigmatism exceeded 3.00 diopters.

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

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

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

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

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

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

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

d. Retina

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

e. Optic Nerve

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

(2) Any optic nerve anomaly.

f. Lens

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

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

g. Ocular Mobility and Motility

(1) Current or recurrent diplopia (368.2).

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

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

h. Miscellaneous Defects and Diseases

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

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

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

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

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

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

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

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

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

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

5. VISION

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

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

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

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

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

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

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

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

6. EARS

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

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

c. History of cochlear implant.

d. Current or history of cholesteatoma (385.3x)

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

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

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

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

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

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

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

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

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

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

8 NOSE, SINUSES, MOUTH, AND LARYNX

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

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

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

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

e. Current anosmia or parosmia (781.1).

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

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

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

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

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

9 DENTAL

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

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

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

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

10 NECK

a. Current symptomatic cervical ribs (756.2).

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

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

11. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM

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

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

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

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

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

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

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

(b) No exacerbations requiring acute medical treatment.

(c) No use of oral steroids.

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

e. Chronic obstructive pulmonary disease (491).

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

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

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

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

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

i. History of empyema (510.9).

j. Pulmonary fibrosis (515).

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

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

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

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

o. Recurrent spontaneous pneumothorax (512.8).

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

12. HEART

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

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

(a) Severe pulmonic regurgitation.

(b) Severe tricuspid regurgitation.

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

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

(e) Moderate or severe mitral regurgitation.

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

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

(a) Trace or mild pulmonic regurgitation.

(b) Trace or mild tricuspid regurgitation.

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

(d) Trace aortic insufficiency.

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

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

d. All valvular stenosis (396).

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

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

g. History of supraventricular tachycardia (427.0).

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

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

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

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

i. Abnormal ECG patterns (794.31):

(1) Long QT (426.82).

(2) Brugada pattern.

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

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

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

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

(1) Sinus arrhythmia.

(2) First degree AV block (426.11).

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

(4) Early repolarization.

(5) Incomplete right bundle branch block.

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

(7) Sinus bradycardia (427.81).

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

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

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

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

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

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

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

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

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

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

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

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

t. History of rheumatic fever (390).

13. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM

a. Esophageal Disease

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

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

(a) Stricture or B-ring.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagitis.

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

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

(~~4~~*3*) History of surgical correction *(fundoplication or dilation)* for GERD within 6 months ~~(P42 esophageal correction, P43 stomach correction, and P45 intestinal correction) (CPT 43257)~~*(45.89)*.

(~~5~~*4*) Current or history of dysmotility disorders ~~and chronic or recurrent esophagitis (530).~~*, to include diffuse esophageal spasm, nutcracker esophagus, non-specific motility disorder, and achalasia.*

(5) Eosinophilic esophagitis.

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

b. Stomach and Duodenum

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

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

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

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

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

(4) History of gastroparesis.

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

(6) History of gastric varices.

c. Small and Large Intestine

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

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

(~~2~~*3*) Current or history of intestinal malabsorption syndromes (579.9), including but not limited to *celiac sprue, pancreatic insufficiency,* post-surgical and idiopathic (579). Lactase

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

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

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

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

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

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

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

d. Hepatic-Biliary Tract

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

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

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

(4) History of sphincter of Oddi dysfunction.

(5) Choledochocyst.

(6) Primary biliary cirrhosis or primary sclerosing cholangitis.

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

(8) Pancreatic cyst.

(9) History of pancreatic surgery.

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

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

e. Anorectal

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

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

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

~~f. Spleen~~

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

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

~~g~~*f*. Abdominal Wall

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

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

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

14. FEMALE GENITALIA

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

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

c. Current unexplained secondary amenorrhea (626.0).

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

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

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

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

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

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

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

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

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

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

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

(1) Current lesions are present.

(2) Chronic suppressive therapy is needed.

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

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

(5) Treatment included hospitalization or intravenous therapy.

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

15. MALE GENITALIA

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

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

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

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

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

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

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

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

i. Current penile curvature if associated with pain.

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

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

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

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

(5) Treatment included hospitalization or intravenous therapy.

k. Current or history of urethral condyloma acuminatum.

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

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

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

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

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

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

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

16. URINARY SYSTEM

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

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

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

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

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

(3) Enuresis (788.30).

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

(5) Urinary retention.

(6) Dysuria.

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

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

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

(1) Gross hematuria (599.7).

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

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

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

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

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

(2) Asymmetry in size or function of kidneys.

(3) History of renal transplant.

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

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

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

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

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

(9) History of acute kidney injury requiring dialysis.

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

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

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

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

17. SPINE AND SACROILIAC JOINTS

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

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

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

(2) It requires external support.

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

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

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

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

(3) It is symptomatic.

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

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

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

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

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

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

(c) Any compression fracture that is symptomatic.

(2) Vertebral fractures that DO MEET the standard:

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

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

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

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

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

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

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

18. UPPER EXTREMITIES

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

(1) Shoulder (726.1)

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) Elbow (726.3)

(a) Flexion to 130 degrees.

(b) Extension to 15 degrees.

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

(4) Hand (726.4)

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

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

b. Hand and Fingers

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

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

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

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

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

(6) Current polydactyly (755.0).

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

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

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

19. LOWER EXTREMITIES

a. General

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

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

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

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

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

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

(d) Abduction to 45 degrees.

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

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

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

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

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle

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

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

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

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

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

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

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

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

(9) Symptomatic neuroma (355.6).

d. Leg, Knee, Thigh, and Hip

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

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

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

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

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

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

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

(6) Meniscal transplant (CPT 29868).

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

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

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

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

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

20. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES

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

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

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

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

e. Fractures

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

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

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

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

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

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

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

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

l. Current osteopenia (733.9) until resolved.

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

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

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

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

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

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

21. VASCULAR SYSTEM

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

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

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

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

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

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

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

22. SKIN AND CELLULAR TISSUES

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

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

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

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

c. Cysts if:

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

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

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

e. Current or chronic lymphedema (457.1).

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

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

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

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

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

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

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

m. Current or history of psoriasis (696.1).

n. Current or history of radiodermatitis (692.82).

o. Current or history of scleroderma (710.1).

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

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

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

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

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

23. BLOOD AND BLOOD-FORMING TISSUES

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

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

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

d. Spleen

(1) Current splenomegaly (789.2).

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

24. SYSTEMIC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Oral allergy syndrome.

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

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

(6) Idiopathic anaphylaxis (995.0).

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

(8) History of systemic allergic reaction or angioedema.

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

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

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

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

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

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

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

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

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

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

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

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

25. ENDOCRINE AND METABOLIC

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

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

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

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

(3) History of gestational diabetes mellitus.

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

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

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

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

f. The following thyroid disorders:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

k. Metabolic bone disease.

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

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

l. Male hypogonadism.

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

26. RHEUMATOLOGIC

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

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

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

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

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

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

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

h. Current or history of gout (274).

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

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

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

l. Current or history of chronic fatigue syndrome.

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

n. Current or history of joint hypermobility syndrome.

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

2~~6~~*7*. NEUROLOGIC

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

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

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

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

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

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

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

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

g. Cluster headaches (339.0).

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

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

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

(3) Persistent impairment of cognitive function.

(4) Persistent alteration of personality or behavior.

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

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

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

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

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

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

i. History of moderate head injury (854.03).

(1) Moderate head injuries are defined as:

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

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

(c) Linear skull fracture.

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

j. History of mild head injury (854.02).

(1) Mild head injury is defined as:

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

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

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

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

l. Current or history of infectious processes of the central nervous system, including but not limited to meningitis (322), encephalitis (323), neurosyphilis (094), or brain abscess (324), if occurring within 1 year before examination, required surgical treatment, or if there are residual neurological defects.

m. Current or history of paralysis, weakness, lack of coordination, chronic pain (including but not limited to chronic regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes (344), including but not limited to Guillain-Barre Syndrome (357.0).

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

o. Chronic nervous system disorders, including but not limited to myasthenia gravis (358.0), multiple sclerosis (340), tremor (333.1), and tic disorders (307.20) (e.g., Tourette's (307.23)).

p. Current or history of central nervous system shunts of all kinds (V45.2).

q. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope (780.2), including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.

2~~7~~*8*. SLEEP DISORDERS

a. Chronic insomnia (780.5). Within the past year, had difficulty sleeping, or used medications to promote sleep for more than 3 nights per week, over a period of 3 months.

b. Sleep-related breathing disorders (327). Current diagnosis or treatment of sleep-related breathing disorders, including but not limited to sleep apnea (327.2).

c. Current or history of narcolepsy, cataplexy (347-347.11), or other hypersomnia disorders (327.13-19).

d. Circadian rhythm disorders requiring treatment (307.45).

e. Current or history of parasomnia (327.44, 327.49), including but not limited to sleepwalking, enuresis, or night terrors (307.46), after the age of 15.

f. Current diagnosis or treatment of sleep-related movement disorders to include restless leg syndrome (327.5).

2~~8~~*9*. LEARNING, PSYCHIATRIC, AND BEHAVIORAL

a. Attention Deficit Hyperactivity Disorder (ADHD) (314) UNLESS the following criteria are met:

(1) The applicant has not required an Individualized Education Program or work accommodations since the age of 14.

(2) There is no history of comorbid mental disorders.

(3) The applicant has never taken more than a single daily dosage of medication or has not been prescribed medication for this condition for more than 24 cumulative months after the age of 14.

(4) During periods off of medication after the age of 14, the applicant has been able to maintain at least a 2.0 grade point average without accommodations.

(5) Documentation from the applicant's prescribing provider that continued medication is not required for acceptable occupational or work performance.

(6) Applicant is required to enter service and pass Service-specific training periods with no prescribed medication for ADHD.

b. History of learning disorders (315), including but not limited to dyslexia (315.02), UNLESS applicants demonstrated passing academic and employment performance without utilization of academic and or work accommodations at any time since age 14.

c. Pervasive developmental disorders (299 series) including Asperger Syndrome, autistic spectrum disorders, and pervasive developmental disorder-not otherwise specified (299.9).

d. Current or history of disorders with psychotic features such as schizophrenic disorders (295), delusional disorders (297), or other and unspecified psychoses (298).

e. History of bipolar disorders (296.4-7) and affective psychoses (296.8).

f. History of depressive disorders, including but not limited to major depression (296), dysthymic disorder (300.4), and cyclothymic disorder requiring outpatient care for longer than 12 months by a physician or other mental health professional (to include V65.40), or any inpatient treatment in a hospital or residential facility.

g. Depressive disorder not otherwise specified (311), or unspecified mood disorder (296.90), UNLESS:

(1) Outpatient care was not required for longer than 24 months (cumulative) by a physician or other mental health professional (to include V65.40).

(2) The applicant has been stable without treatment for the past 36 continuous months.

(3) The applicant did not require any inpatient treatment in a hospital or residential facility.

h. History of a single adjustment disorder (309) within the previous 3 months, or recurrent episodes of adjustment disorders.

i. Current or history of disturbance of conduct (312), impulse control (312.3), oppositional defiant (313.81), other behavior disorders (313), or personality disorder (301).

(1) History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups), interview, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in the Military Services.

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

j. Encopresis (307.7) after 13th birthday.

k. History of anorexia nervosa (307.1) or bulimia (307.51).

l. Other eating disorders (307.50; 52-54) including unspecified disorders of eating (307.59) occurring after the 13th birthday.

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

n. History of suicidal behavior, including gesture(s) or attempt(s) (300.9) or history of self-mutilation or injury used as a way of dealing with life and emotions.

o. History of obsessive-compulsive disorder (300.3) or post-traumatic stress disorder (309.81).

p. History of anxiety disorders (300.01), anxiety disorder not otherwise specified (300.00), panic disorder (300.2), agoraphobia (300.21, 300.22), social phobia (300.23), simple phobias (300.29), other acute reactions to stress (308) UNLESS:

(1) The applicant did not require any treatment in an inpatient or residential facility.

(2) Outpatient care was not required for longer than 12 months (cumulative) by a physician or other mental health professional (to include V65.40).

(3) The applicant has not required treatment (including medication) for the past 24 continuous months.

(4) The applicant has been stable without loss of time from normal pursuits for repeated periods even if of brief duration; and without symptoms or behavior of a repeated nature that impaired social, school, or work efficiency for the past 24 continuous months.

q. Current or history of dissociative, conversion, or factitious disorders (300.1), depersonalization (300.6), hypochondriasis (300.7), somatoform disorders (300.8), or pain disorder related to psychological factors (307.80 and .89).

r. Current or history of psychosexual conditions (302), including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.

s. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305.0), or other drug abuse (305.2 thru 305.9).

t. Current or history of other mental disorders (all 290-319 not listed) that, in the opinion of the civilian or military medical examiner, shall interfere with or prevent satisfactory performance of military duty.

u. Prior psychiatric hospitalization for any cause.

~~29~~*30*. TUMORS AND MALIGNANCIES

a. Current benign tumors ~~(M8000)~~ or conditions that interfere with function, prevent the proper wearing of the uniform or protective equipment, shall require frequent specialized attention, or have a high malignant potential, such as Dysplastic Nevus Syndrome.

b. Current or history of malignant tumors (V10).

c. Skin cancer (other than malignant melanoma) that is removed with no residual DOES meet the standard.

3~~0~~*1*. MISCELLANEOUS

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

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

c. Current or history of cold-related disorders, including but not limited to frostbite, chilblain, immersion foot (991), or cold urticaria (708.2).

d. Current residual effects of cold-related disorders (991.9), including but not limited to paresthesias, easily traumatized skin, cyanotic amputation of any digit, ankylosis, trench foot, or deep-seated ache.

e. History of angioedema, including hereditary angioedema (277.6).

f. History of receiving organ or tissue transplantation (V42).

g. History of pulmonary (415) or systemic embolization (444).

h. History of untreated acute or chronic metallic poisoning, including but not limited to lead, arsenic, silver (985), beryllium (985.3), or manganese (985.2), or current complications or residual symptoms of such poisoning.

i. History of heat pyrexia (992.0), heatstroke (992.0), or sunstroke (992.0).

j. History of three or more episodes of heat exhaustion (992.3).

k. Current or history of a predisposition to heat injuries (992.0-992.8), including disorders of sweat mechanism (705.0-705.9), combined with a previous serious episode.

l. Current or history of any unresolved sequelae of heat injury (992.0-992.8), including but not limited to nervous, cardiac, hepatic, or renal systems.

m. Current or history of any condition that, in the opinion of the medical officer, shall significantly interfere with the successful performance of military duty or training (should use specific ICD code whenever possible, or 796.9).

n. Any current acute pathological condition, including but not limited to acute communicable diseases, until recovery has occurred without sequelae.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ADHD	Attention Deficit Hyperactivity Disorder
ANSI	American National Standards Institute
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ATS	American Thoracic Society
AV	atrioventricular
CPT	Current Procedural Terminology
CREST	Calcinosis, Raynaud's phenomenon, Esophogeal dysmotility, sclerodactyly, telangiectasia
dB	decibel
DEP	Delayed Entry Program
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DUSD(MPP)	Deputy Under Secretary of Defense for Military Personnel Policy
ECG	electrocardiograph
GERD	Gastro-Esophageal Reflux Disease
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
ICD	International Classification of Diseases
LASEK	laser epithelial keratomileusis
LASIK	laser-assisted in situ keratomileusis
LDL	*low-density lipoprotein*
LTBI	latent tuberculosis infection
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dl	milligrams per deciliter
mmHg	millimeters of mercury
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health
PRK	photorefractive keratectomy
PDASD(HA)	Principal Deputy Assistant Secretary of Defense for Health Affairs
PDES	Physical Disability and Evaluation System
PDUSD(P&R)	Principal Deputy Under Secretary of Defense for Personnel and Readiness

QFT®-G	QuantiFERON®-TB Gold
ROTC	Reserve Officer Training Corps
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USPHS	United States Public Health Service
WPW	Wolff-Parkinson-White

PART II. DEFINITIONS

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

anemia. A hemoglobin level of less than 13.5 for males and less than 12 for females.

Department of Health and Human Services (HHS). The U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Military Department. Defined in Joint Publication 1-02 (Reference (j)).

Military Service(s). Defined in Reference (j).

NHLBI. An agency within the National Institutes of Health (NIH) that provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.

NIH. An agency within the HHS that serves as the steward of medical and behavioral research for the Nation. Its mission is science in pursuit of fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability.

QFT®-G. An in vitro laboratory diagnostic test using a whole blood specimen. It is an indirect test for Mycobacterium tuberculosis-complex (i.e., M. tuberculosis, M. bovis, M. africanum, M. microti, M. canetti) infection, whether tuberculosis disease or latent tuberculosis infection (LTBI). It cannot distinguish between tuberculosis disease and LTBI, and is intended for use in conjunction with risk assessment, radiography, and other medical and diagnostic evaluations.

EXHIBIT B

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

AFI48-123_AFGM2018-02

28 January 2018

MEMORANDUM FOR ALMAJCOM/SG

FROM: HQ USAF/SG
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Guidance Memorandum – Air Force Instruction 48-123, *Medical Examinations and Standards*

By Order of the Secretary of the Air Force, this memorandum immediately implements changes to Air Force Instruction 48-123.

This memorandum restates previous Guidance Memo (GM) AFGM 2016-01 dated 19 September 2016, which provides substantial changes to improve upon guidance regarding medical examinations and standards. It incorporates the previous Guidance Memo (GM) and also adds direction for implementing and monitoring remotely piloted aircraft (RPA) pilot standards. Further, this Guidance Memo (GM) clarifies the definitions for the USAF Medical Serial Profile Annotation [Physical Profile Serial Chart (PULHES)] and incorporates recommendations for clarifying language for Duty Not Involving Flying (DNIF) procedures following a mishap. It also officially adopts the DoD equivalent to AF Form 1042, the DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*.

Compliance with this memorandum is mandatory. To the extent its directions are inconsistent with other Air Force publications, the information herein prevails, in accordance with Air Force Instruction 33-360, *Publications and Forms Management.*

This memorandum becomes void after one year has elapsed from the date of this Memorandum, or upon publication by interim change to, or rewrite of AFI 48-123, whichever is earlier.

MARK A. EDIGER
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment:
Changes to Air Force Instruction 48-123
(Add) Opening Paragraph. The authorities to waive wing/unit level requirements in this publication are identified with a Tier (“T-0, T-1, T-2, T-3”) number following the compliance

statement. See Air Force Instruction 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items.

1.1.2. (Add) The current Medical Standards Directory is located on the Knowledge Exchange under Flight Medicine in the Medical Standards Directory folder.

1.1.2.1. (Add) The Medical Standards Directory and the Official Air Force Medicine Approved Medications must be used in accordance with Air Force Instruction 48-123 and can be changed through the process noted in Air Force Instruction 48-123 Guidance Memo (GM) para. 1.1.2.2.

1.1.2.2. (Add) Medical standards and aircrew approved medications are changed through a process that includes review by the Aircrew Medical Standards Working Group (AMSWG) which includes members from Major Commands (MAJCOM), HAF/A3, and appropriate Subject Matter Experts for the specific standards. Then any recommended changes by the Aircrew Medical Standards Working Group (AMSWG) are reviewed by the Flight and Operational Medicine Corporate Board whose voting members include the Major Command (MAJCOM)/SGPs. All medical standards are approved in accordance with the AF/SG's delegated authority. For retention and all special duty medical standards (including flying) the delegated authority is the AF/SG3/5P.

1.1.2.3. (Add) The Chief of Physical Standards Development is the OPR for any changes and can be contacted for any recommendations.

1.2.4.5. (Replace) Color Vision Testing: Pseudoisochromatic Plate (PIP) testing to determine color vision perception will be completed at accession, and the results will be recorded in member's record (T-2). [Special Operational Duty (SOD) positions include but are not limited to Ground Based Controller (GBC), Survival, Evasion, Resistance, and Escape (SERE), Pararescue (PJ) and Combat Control.] If an applicant wants to apply for flying or special duty, then they must pass the Cone Contrast Test (CCT) at an Air Force Military Treatment Facility (MTF) or equivalent. (T-1) Exception: See section 3.1.3 for applicants for Initial Flying Class I and Initial Flying Class II/Flight Surgeon (IFCII/FS) and remotely piloted aircraft (RPA) duties.

1.2.8. (Replace) **Disorders That Are Unsuiting**. Disorders that are unsuiting for, or interfere with, military service are managed administratively through the patient's chain of command in accordance with Air Force Instruction 36-3206, *Administrative Discharge Procedures for Commissioned Officers* and Air Force Instruction 36-3208, *Administrative Separation of Airmen*. Unsuiting disorders are conditions that interfere with military service and must not be confused with disorders that render a member medically unfit for duty. These conditions are not entered into the Integrated Disability Evaluation System (IDES), in accordance with DoDI 1332.18, Disability Evaluation System (DES) paragraph 3.i.

2.7.5.2. (Add) Retraining applications will be reviewed by the primary care provider at the request of the Medical Standards Management Element (MSME). (T-1) The provider will then update the Physical Profile Serial Chart (PULHES) (see Table A3.1) for the applicant in an AF Form 422 in accordance with Air Force Instruction 10-203, *Duty Limiting Conditions*. (T-2)

2.9.5. (Add) Retraining applications will be reviewed by the Medical Standards Management Element (MSME) to ensure members are qualified for entry into the Air Force Specialty Codes (AFSC) for which the member is applying in accordance with Air Force Instruction 10-203. (T-1) Medical Standards Management Element (MSME) will ensure Physical Profile Serial Chart (PULHES) (see Table A3.1) is updated in accordance with Air Force Instruction 10-203. (T-1)

5.3.3.1. (Replace) Certain conditions render an individual unsuited for duty, rather than unfit, and render the service member subject to administrative separation since these conditions interfere with military service. These conditions cannot be entered into the Integrated Disability Evaluation System (IDES). Consult Air Force Instruction 36-3206, *Administrative Discharge Procedures for Commissioned Officers*, Air Force Instruction 36-3208, *Administrative Separation of Airmen*, and DoDI 1332.18, *Disability Evaluation System (DES)* for details and specific cases.

6.1.1.3.2. (Replace) Rated officers for continued flying duty (pilots, navigators/electronic warfare officers, 12SX Special Operations Combat Systems Officer and flight surgeons).

6.1.1.5. (Replace) Flying Class (FC) III qualifies individuals for aviation as indicated in the Air Force Officer Classification Directory (AFOCD) or the Air Force Enlisted Classification Directory (AFECD). For United States Air Force Academy (USAFA) cadets participating in United States Air Force Academy (USAFA) cadet airmanship program, see Air Force Instruction 48-123 paragraph 6.24.6. A categorical Flying Class III (FCIII) qualifies individuals for duty with certain restrictions. Granting categorical certifications and waivers does not guarantee operational utilization. Restrictions for Flying Class IIIC (FCIIIC) and Flying Class IIID (FCIIID) will be documented in the remarks section of the AF Form 1042 or DD Form 2992. (T-1) See Air Force Instruction 48-123 paragraph 6.4. and Table A2.1. for certification and waiver authority.

6.1.1.5.1. (Add) Flying Class IIIC (FCIIIC) qualifies individuals for aviation duty as specified in the remarks section of AF Form 1042 or DD Form 2992. Example: Restricted to current and previously qualified systems. If using new systems requiring interpretation of different color symbology, an operational evaluation is required to verify capability to accurately recognize and respond to all display information.

6.1.1.5.2. (Add) Flying Class IIID (FCIIID) qualifies individuals for aviation duties that do not require stereopsis per the career field manager (CFM), as documented in the Air Force Officer Classification Directory (AFOCD) or Air Force Enlisted Classification Directory (AFECD).

6.1.1.7. (Add) Remotely piloted aircraft (RPA) pilot exam qualifies rated officers for remotely piloted aircraft (RPA) pilot duties only. Undergraduate Remotely Piloted Aircraft Training (URT) requires Initial Flying Class II (IFCII) (see 6.1.1.3.1).
6.1.1.7.1. (Add) Remotely piloted aircraft (RPA) pilots with Air Force Specialty Codes (AFSC) 11X or 12X who may return to manned aviation platforms should maintain Flying Class II (FCII) standards. For day-to-day operations, the pilots shall follow remotely piloted aircraft (RPA) pilot medical, Duty Not Involving Flying (DNIF) and waiver requirements. Special

attention must be paid to 11X or 12X remotely piloted aircraft (RPA) pilots to identify medical conditions which may require a Flying Class II (FCII) waiver prior to their return to manned aviation platforms.

6.1.1.7.2. (Add) Remotely piloted aircraft (RPA) pilots who have been granted a Flying Class IIU (FCIIU) categorical waiver shall follow the remotely piloted aircraft (RPA) Pilot standards with Duty Not Involving Flying (DNIF) and waiver requirements. A new waiver is required to have the Flying Class IIU (FCIIU) restriction removed if the pilot seeks to return to manned aviation [Air Force Medical Support Agency (AFMSA) retains waiver authority].

6.4.1.1. (Change) All initial and renewal categorical flying waivers; changes from one category to another; removal of a categorical restriction. Exceptions are for specific cases where AFMSA/SG3PF delegates to Major Command or in an official delegation letter from AFMSA/SG3PF (maintained on the Knowledge Exchange). These cannot be further delegated to the base level.

6.4.1.9.1. (Add) AFMSA/SG3PF delegates to AETC/SGPS, AFRC/SG or ANG State Air Surgeon (in accordance with Table A2.1) the authority for initial Flying Class IIID (FCIIID) certification for untrained personnel who do not require depth perception as stated in the Air Force Officer Classification Directory (AFOCD) or Air Force Enlisted Classification Directory (AFECD). See Air Force Instruction 48-123 Guidance Memo (GM) paragraph 6.1.1.5.2.

6.4.1.9.2. (Add) AFMSA/SG3PF delegates to Major Command, AFRC/SG or ANG/SG (in accordance with Table A2.1) the waiver authority for Flying Class IIID (FCIIID) waivers in trained personnel who do not require depth perception as stated in the Air Force Officer Classification Directory (AFOCD) or Air Force Enlisted Classification Directory (AFECD). See Air Force Instruction 48-123 Guidance Memo (GM) paragraph 6.1.1.5.2.

6.4.3.1. (Replace) Command and United States Air Force Academy (USAFA) surgeons may delegate waiver authority to another command surgeon or to a Residency Trained Aerospace Medicine specialist working on that Major Command staff [Aerospace Medicine Specialist (Air Force Specialty Code (AFSC) 48A], Air Force Specialty Code (AFSC) 48A3/48A4 or Air Reserve Component (ARC) 48R3/48R4). Exceptions will be approved by AFMSA/SG3P. Command surgeons may delegate base level (local) waiver authority to the installation Aerospace Medicine Specialist or most qualified flight surgeon, most likely the Chief of Aerospace Medicine (SGP), in accordance with paragraph 2.3.1. Waiver delegation will indicate authority based on residency trained Aerospace Medicine Specialist [Aerospace Medicine Specialist (AFSC 48A)] versus non Aerospace Medicine Specialist. Note: Authority to grant Flying Class III waivers to rated personnel who have been medically disqualified for Flying Class II is delegated to the member's Major Command/SG of assignment. See paragraph 6.4.1.11.

6.7.1.1. (Add) When an aviator or operator is in Duty Not Involving Flying (DNIF), Duty Not Involving Controlling (DNIC), Duty Not Involving Jump (DNIF), Duty Not Including Alert (DNIA) status, there may be other duties that can be performed. Clearance for simulator training,

ground-based flight line duties (to include Supervisor of Flying) and/or other duties may be annotated on the AF Form 1042 or DD Form 2992.

6.7.5.1. (Add)"Involved in an aircraft mishap" is usually defined as all military crewmembers on the flight orders of the mishap aircraft, as well as all members of the mishap flight if the mishap aircraft was part of a formation. The AF Form 1042 or DD Form 2992 will temporarily Duty Not Involving Flying (DNIF) aircrew for subsequent flight duties as appropriate.

6.21. (Replace) Medical Standards. For accessions and enlistments, the standards in Chapter 4 apply. Chapter 5 and the Medical Standards Directory apply to personnel already serving as active duty (AD) or Air Reserve Component (ARC) [example, active duty SSgt applying for Initial Flying Class I (IFCI) duty must meet retention standards in Chapter 5, as well as Initial Flying Class I (IFCI) standards in the Medical Standards Directory]. For conditions listed in Chapter 5 and the Medical Standards Directory, ensure an initial Review in lieu of Medical Evaluation Board (I/RILOMEB) or Medical Evaluation Board/Fitness for Duty (MEB/FFD) has been initiated if appropriate. The medical standards for Special Operational Duty (SOD) exams are based on Air Force Special Code (AFSC), Flying Class (FC) and special duties; for medical standards reference the requirements in the Air Force Officer Classification Directory (AFOCD), Air Force Enlisted Classification Directory (AFECD), this section, 6H, 6I, 6J, and the Medical Standards Directory (MSD) paying special attention to the notes at the top of each subheading.

6.22. (Replace) Ground Based Aircraft Controller Medical Standards. The standards in Section 6H and the Medical Standards Directory apply to all ground based aircraft controllers which includes air traffic controller, weapons controllers/directors, combat controllers, Tactical Air Control Party (1C4X1), Air Liaison Officer (13LX) and remotely piloted aircraft (RPA) sensor operators (1U0X1). Conditions in Chapter 5 and the Medical Standards Directory or Worldwide Duty (WWD) standards also apply. For conditions listed in Chapter 5 and the Medical Standards Directory, ensure an initial Review in lieu of Medical Evaluation Board (I/RILOMEB) or Medical Evaluation Board (MEB) has been initiated if appropriate.

6.24.3.3.6. (Add) Physiologic training participants without an AF Form 1042 (or DD Form 2992) and the above completed, will complete a medical history and examination based upon Air Force Instruction 48-123 paragraph 6.24.2. Operational Support Flying (OSF) Duty.

6.24.6.1. (Replace) Flying Class III standards apply to Dean of Faculty (DF) parachute courses. Remotely piloted aircraft (RPA) Pilot standards apply to all Dean of Faculty (DF) remotely piloted aircraft (RPA) programs. Flying Class II standards apply to all soaring/powered flight courses. The following exceptions apply:

6.24.7.1. (Replace) Pilots of fighter, rotary wing, fixed wing (non-fighter) and remotely piloted aircraft transferring from sister service to an equivalent weapon system in the Air Force are considered trained assets, Flying Class II (FCII) or remotely piloted aircraft (RPA) pilot standards apply as appropriate. Complete all requirements for pilot’s age in accordance with Periodic Health Assessment (PHA) and Aerospace Medicine Information Management System (ASIMS) guidelines. This physical will be entered into Physical Examination and Processing

Program (PEPP) for baseline comparison and into Aeromedical Information Management Waiver Tracking System (AIMWTS) if flying waiver required.

6.24.7.2. (Add) Pilots of fighter, rotary wing, fixed wing (non-fighter) and remotely piloted aircraft transferring to the AF from a different type of weapon system are not considered trained assets. Flying Class I standards apply for manned aviation platforms. These pilots would require initial Flying Class I (FCI) physical and successful completion of Medical Flight Screening (MFS). For those transferring into remotely piloted aircraft (RPA), IFCII standards apply (see 6.1.1.3.). This physical will be entered into Physical Examination and Processing Program (PEPP) and into Aeromedical Information Management Waiver Tracking System (AIMWTS) if flying waiver required.

6.24.8. (Add) Hyperbaric Duty.

6.24.8.1. (Add) The conditions listed in Chapter 5 and the Operational Support Flyer column of the Medical Standards Directory are disqualifying for personnel conducting hyperbaric duties within the chamber.

6.24.8.2. (Add) Personnel who perform hyperbaric duties are required to have a normal examination of tympanic membranes, lungs and chest, heart, abdomen, neurologic, weight, blood pressure and pulse documented in their health record for an initial examination. The exam's expiration date is the Periodic Health Assessment (PHA) expiration date. Note: AF Form 1042 or DoD equivalent is issued as satisfactory evidence of completion of the requirements outlined for training and duty. This examination does not need to be entered into Physical Examination and Processing Program (PEPP).

6.24.9. (Add) Small Unmanned Aircraft Systems Operators. Must meet standards for continued military service (Retention) and Section U: Small Unmanned Aircraft Systems Operators Standards as listed in the Medical Standards Directory. (T-1)

(Replace entire Chapter 7)

CHAPTER 7
MEDICAL EXAMINATIONS FOR SEPARATION AND RETIREMENT

AFI48-123_AFGM2018-02
Changes to Air Force Instruction 48-123

7.1. Policy. This is the AF policy implementing the DoD Separation History and Physical Examination (SHPE) in accordance with *Directive-Type Memorandum (DTM) 14-006, Separation History and Physical Examination (SHPE).* Do not delay separation or retirement past scheduled date of separation or retirement to complete a medical examination unless medical hold is approved (see Air Force Instruction 41-210, *TRICARE Operations and Patient Administration,* for further guidance on medical hold authority and related topics).

7.2. Purpose. To identify medical conditions requiring attention, to document current medical status, and potentially assist with the evaluation of disability claims.

7.3. Presumption of Fitness. Except for Service members previously determined unfit and continued in a permanent limited duty status, Service members who have been referred for a Separation History and Physical Examination (SHPE) because of retirement or separation are presumed fit for retention. Service members will therefore only be referred to the Disability Evaluation System or Integrated Disability Evaluation System (IDES) if a condition that would prevent the member from performing further duty if he or she were not separating or retiring is detected at the time of the Separation History and Physical Examination (SHPE) and the referral is in accordance with DoD Instruction 1332.18 (Appendix 1 to Enclosure 3).

7.4. Law Governing Disability Evaluation.

7.4.1. Title 10, United States Code, Chapter 58, outlines benefits and service for members being separated from the armed forces.

7.4.2. Title 38, United States Code, administered by the Department of Veterans Affairs governs disability compensation for ratable service-connected defects.

7.4.3. Title 10 United States Code Section 1145 directs conduct of separation examinations on specific individuals leaving the armed forces.

7.5. Mandatory Separation History and Physical Examination (SHPE)

7.5.1. All members of the Military Services, to include Reserve Component (RC) service members, who are scheduled to be separated (deactivated) from active duty after serving for 180 days or more, will undergo a comprehensive Separation History and Physical Examination (SHPE) prior to the scheduled date of separation (deactivation). (T-0) Reserve Component (RC) service members serving on active duty for a period of more than 30 days in support of a contingency operation, will also undergo a Separation History and Physical Examination (SHPE) prior to the date of separation (demobilization) from active duty service in accordance with Directive-Type Memorandum (DTM) 14-006. (T-0)
7.5.1.1. Reserve Component (RC) service members serving on active duty for less than 180 days or on active duty for training, other training duty, not annual training as defined in DoDI 1215.06 or other non-mobilization orders are not required to undergo a Separation History and Physical Examination (SHPE), but will document their current health status and complete DD Form 2697, “Report of Health Assessment,” before completing their scheduled tour of duty.

7.5.1.2. Except for service members previously determined unfit and continued in a permanent limited duty status, service members who have been referred for a Separation History and Physical Examination (SHPE) because of retirement or separation are presumed fit for retention. Service members will therefore only be referred to the Disability Evaluation System or Integrated Disability Evaluation System (IDES) if a condition that would prevent the member from performing further duty if he or she were not separating or retiring is detected at the time of the Separation History and Physical Examination (SHPE) and the referral is in accordance with DoD Instruction 1332.18 and *Separation History and Physical Examination (SHPE) Guide.*

7.5.1.3. Separation History and Physical Examination (SHPE) requirements under this Air Force Instruction are in addition to any deployment health activities specified in DoD Instruction 6490.03, Deployment Health, and Air Force Instruction 48-122, Deployment Health.

7.5.1.4. Active component or Reserve Component service members who intend to remain in the Selected Reserve upon separation from active duty and who elect to file a pre-separation disability claim with the Department of Veterans Affairs must complete Separation History and Physical Examination (SHPE) through the Military Health System or through the Department of Veterans Affairs before separation. (T-3)

7.5.2. The Separation History and Physical Examination (SHPE) examination will be completed by the DoD if the service member does not wish to file a disability claim with the Department of Veterans Affairs prior to the member's separation or retirement. The DoD will also complete the Separation History and Physical Examination (SHPE) when Department of Veterans Affairs is unable to complete the examination within the timelines required or there is not access to the VA within the local area. (T-0)

7.5.2.1. The Primary Care Manage Team or Primary Care Clinic assigned will complete their empaneled members' Separation History and Physical Examination (SHPE) requirements unless a Military Treatment Facility (MTF) supplement is approved by Air Force Instruction 48-123 OPR or waiver provided by AFMSA/SG3PF [see *Separation History and Physical Examination (SHPE) Guide*]. For active duty not enrolled to the Military Treatment Facility (MTF) (i.e. TRICARE Overseas Prime Remote or TRICARE Prime Remote), the supporting Military Treatment Facility (MTF) responsible for out-processing the Service member will complete Separation History and Physical Examination (SHPE) requirements.

7.5.2.2. If not completed by the Department of Veterans Affairs, ARC service members should complete the mandated Separation History and Physical Examination (SHPE) as directed by the Military Treatment Facility (MTF) or as per *Separation History and Physical Examination (SHPE) Guide*. Travel costs will be included as applicable. [See Separation History and Physical Examination (SHPE) Guide.]

7.5.2.3. USAF facilities should instruct Navy and Army Reserve Component service members to complete their examinations through their mobilization/demobilization facilities or to other locations directed by their service.

7.5.3. Timing of Separation History and Physical Examination (SHPE). Refer to Directive-Type Memorandum (DTM) 14-006 and subsequent DoDI for the timing of the Separation History and Physical Examination (SHPE). Please review to the *Separation History and Physical Examination (SHPE) Guide* for guidance on how to execute the requirements.

7.5.4. DoD Separation History and Physical Examination (SHPE) Components complete, per Directive-Type Memorandum (DTM) 14-006, at a minimum:

7.5.4.1. DD Form 2807-1, *Report of Medical History*, completed by service member and signed by a licensed, privileged healthcare provider. (T-0)

7.5.4.1.1. The DD Form 2807-1 completed by the service member is available for the privileged provider performing the physical examination at the time of the encounter.

7.5.4.1.2. A face-to-face interview with a licensed, privileged healthcare provider to discuss care and services for medical concerns subsequent to their completion of the self-reported health assessment is conducted with the service members.

7.5.4.1.3. The privileged health care provider reviews the service member's complete medical history; current worldwide medical qualification status; the member's current health status; and need for referral for treatment or further evaluations for medical concerns.

7.5.4.1.4. All positive responses on the DD Form 2807-1 are addressed with comments by the privileged provider performing the Separation History and Physical Examination (SHPE).

7.5.4.2. DD Form 2808, *Report of Medical Examination*, as noted below, completed by a privileged provider. This includes a review of medical record and a record of significant medical conditions. (T-0)

7.5.4.2.1. Blocks, 1-44, 53, 54, 57, 58, 77 and 85.

7.5.4.2.2. Block 71 unless the threshold audiogram is contained in the Service Treatment Record (STR). See paragraph 7.5.4.3.

7.5.4.3. Threshold audiogram documented on DD Form 2808 threshold unless a recent audiogram [within 6 months of the Separation History and Physical Examination (SHPE)] is documented in the Service Treatment Record (STR). (T-0) Note: Unless the Service member is a member of the Hearing Conservation Program, an AF Form 1753, *Hearing Conservation Examination*, is NOT required.

7.5.4.4. Complete audiology evaluation if the threshold audiogram is abnormal. (T-0)

7.5.4.5. Optional Hepatitis C testing per Centers for Disease Control and Prevention (CDC) guidelines. (T-0)

7.5.4.6. Additional testing appropriate to the service member's health status, as determined by the examining licensed provider and in accordance with current DoD policy.

7.5.4.7. Verification that all occupational health examinations required by DoD policy (e.g., hearing conservation, radiation medical surveillance) have been completed before the Separation History and Physical Examination (SHPE) is conducted.

7.5.4.8. Other Tests. Any periodic testing required by other issuances [e.g., HIV testing in accordance with DoD Instruction 6485.01 (Reference (j)] must be completed before referral for Separation History and Physical Examination (SHPE).

7.5.4.9. Any examination completed on DD Forms 2807-1 and 2808, threshold audiogram, laboratory testing, or other exams performed for any other reason that meets any of the requirements stated in paragraphs 7.5.4.1. and 7.5.4.2. within the time periods stated in paragraph 7.5.3. of this guidance memorandum is sufficient to meet this requirement, but only with the consent of the Service member and concurrence of the member's unit commander. If another examination documented on a DD Form 2807-1 and DD Form 2808 performed within the previous 12 months is used to meet this requirement, and more than 60 days have elapsed since the date of the qualifying examination, the Service member must complete a standard DD Form 2697. (T-0)

7.5.4.10. When the Separation History and Physical Examination (SHPE) is completed by the DoD, the following documentation is required, at a minimum:

7.5.4.10.1. A medical encounter note must be included in the service treatment record when completed by DoD. (T-0) The note must include the DD Form 2807-1 in Healthcare Artifact and Imaging Management Solution (HAIMS), and either the DD Form 2808 in Healthcare Artifact and Imaging Management Solution (HAIMS) or a medical record template may be used in lieu of completing a separate form if it includes all the essential elements of the DD Form 2808. (T-1)

7.5.4.10.2. The encounter note must include the accepted diagnosis code for a Separation History and Physical (V70.5_9) for the first diagnosis. (T-1)

7.5.4.10.3. The summary list of diagnoses from the DD Form 2808 should all be included in the Problem List or added in the electronic medical record with the Separation History and Physical Examination (SHPE) encounter. (T-1)

7.5.4.10.4. Validate that service member meets medical requirements for retirement and/or separation. (T-1)

7.5.4.11. See Directive-Type Memorandum (DTM) 14-006 for additional information.

7.5.5. DoD Responsibilities when Separation History and Physical Examination (SHPE) performed at the Department of Veterans Affairs.

7.5.5.1. Ensure the Separation History and Physical Examination (SHPE) is complete and inserted into the Service Treatment Record (STR) per *Separation History and Physical Examination (SHPE) Guide.* (T-1)

7.5.5.2. DoD Provider reviews the Separation History and Physical Examination (SHPE).

7.5.5.2.1. The encounter note must include the accepted diagnosis code for a Separation History and Physical (V70.5_9) as the first diagnosis. (T-1)

7.5.5.2.2. Add new clinical diagnoses into the Service Treatment Record (STR) and provide appropriate medical care in accordance with DoD Policy. (T-1)

7.5.5.2.3. Validate that service member meets medical requirements for retirement and/or separation. (T-1)

7.5.6. If a medical condition is noted during a Separation History and Physical Examination (SHPE) which may delay retirement and/or separation, the reviewing provider will follow instructions in accordance with Air Force Instruction 41-210. In addition, they will inform the Medical Standards Management Element (MSME) and/or Deployment Availability Working Group (DAWG) of potential delay. (T-1) See paragraph 7.5.1.2. and *Separation History and Physical Examination (SHPE) Guide* for additional details.

7.6. General Officers. Examinations for retirement must be conducted in accordance with this policy and Air Force Instruction 36-3203, *Service Retirements*.

7.7. Separation History and Physical Examination (SHPE) Metrics. Separation History and Physical Examination (SHPE) required tracking will be completed in accordance with Directive-Type Memorandum (DTM) 14-006 requirements.

Attachment 1. (Add) ***Adopted Forms*** DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*, http://www.esd.whs.mil/Portals/54/Documents/DD/forms/dd/dd2992.pdf.

Attachment 3
Table A3.1. Physical Profile Serial Chart (PULHES) (Add)

	1	2	3	4

P: Physical Condition	Free of any identified organic defect or systemic disease.	Presence of stable, minimally significant organic defect(s) or systemic diseases(s). Capable of all basic work commensurate with grade and position. May be used to identify minor conditions that might limit some deployments to specific locations.	Significant defect(s) or disease(s) under good control. Capable of all basic work commensurate with grade and position.	Organic defect, systemic or infectious disease which requires, or is currently undergoing, an Medical Evaluation Board (MEB) or Initial Review in lieu of Medical Evaluation Board (IRILOMEB) as determined by the Deployment Availability Working Group (DAWG).
U: Upper Extremities	Bones, joints, and muscles normal. Able to do hand-to-hand fighting.	Slightly limited mobility of joints, mild muscular weakness or other musculoskeletal defects that do not prevent hand-to-hand fighting and are compatible with prolonged effort. Capable of all basic work commensurate with grade and position.	Defect(s) causing moderate interference with function, yet capable of strong effort for short periods. Capable of all basic work commensurate with grade and position.	Severely compromised strength, range of motion, or general efficiency of the hand, arm, shoulder girdle, or back (includes cervical and thoracic spine) which requires, or is currently undergoing, an Medical Evaluation Board (MEB) or Initial Review in lieu of Medical Evaluation Board (IRILOMEB) as determined by the Deployment Availability Working Group (DAWG).
L: Lower Extremities	Bones, muscles, and joints normal. Capable of performing long marches, continuous standing, running, climbing, and digging without limitation.	Slightly limited mobility of joints, mild muscular weakness, or other musculoskeletal defects that do not prevent moderate marching, climbing, running, digging, or prolonged effort. Capable of all basic work commensurate with grade and position.	Defect(s) causing moderate interference with function, yet capable of strong effort for short periods. Capable of all basic work commensurate with grade and position.	Severely compromised strength, range of motion, or efficiency of the feet, legs, pelvic girdle, lower back, or lumbar vertebrae which requires, or is currently undergoing, an Medical Evaluation Board (MEB) or Initial Review in lieu of Medical Evaluation Board (IRILOMEB) as determined by the Deployment Availability Working Group (DAWG).
H: Hearing (Ears). See Table A3.2.				
E: Vision (Eyes)	Minimum vision of 20/200 correctable to 20/20 in each eye.	Vision correctable to 20/40 in one eye and 20/70 in the other, or 20/30 in one eye and 20/200 in the other eye, or 20/20 in one eye and 20/400 in the other eye.	Vision that is worse than E-2 profile.	Visual defects worse than E-3 which requires, or is currently undergoing, an Medical Evaluation Board (MEB) or Initial Review in lieu of Medical Evaluation Board (IRILOMEB) as determined by the Deployment Availability Working Group (DAWG).
S: Psychiatric Stability	Diagnosis or treatment results in no impairment or potential impairment of duty function, risk to the mission or ability to maintain security clearance.	World Wide Qualified and diagnosis or treatment result in low risk of impairment or potential impairment that necessitates command consideration of changing or limiting duties.	World Wide Qualified and diagnosis or treatment result in medium risk due to potential impairment of duty function, risk to the mission or ability to maintain security clearance.	Diagnosis or treatment resulting in high to extremely high risk to the AF or patient due to potential impairment of duty function, risk to the mission or ability to maintain security clearance which requires, or is currently undergoing, an Medical Evaluation Board (MEB) or Initial Review in lieu of Medical Evaluation Board (IRILOMEB) as determined by the Deployment Availability Working Group (DAWG).

(Add) **Table A3.2. Hearing Profile**

Acceptable audiometric hearing level for Air Force
Unaided hearing loss in either ear with no single value greater than:

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Changes to Air Force Instruction 48-123

Frequency (Hz)	500	1000	2000	3000	4000	6000	Comments
H-1	25	25	25	35	45	45	Class I and IA, IFCII, IFCIII, Air Force Academy, Ground Based Controller (GBC), and selected career fields as noted in the Officer and Enlisted Classification directories.
H-2	35	35	35	45	55	--	Air Force enlistment, commission, initial Missile Operations Duty (MOD), Survival, Evasion, Resistance, and Escape (SERE), continued Ground Based Controller (GBC), flyers require evaluation for continued flying (see Aircrew waiver guide for details on the evaluation).
H-3	Any loss that exceeds the values noted above, but does not qualify for H-4.						H-3 profile requires evaluation and Major Command waiver for continued flying, and Audiology evaluation for fitness for continued active duty.
H-4	Hearing loss sufficient to preclude safe and effective performance of duty, regardless of level of pure tone hearing loss, and despite use of hearing aids.						This degree of hearing loss is disqualifying for all military duty. These require evaluation for continued service via either Air Reserve Component Fitness for Duty (FFD), Worldwide Duty (WWD) processing, or review by the Deployment Availability Working Group (DAWG) in accordance with Air Force Instruction 10-203 and 41-210 for Initial Review in lieu of Medical Evaluation Board

BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 48-123

5 NOVEMBER 2013

Aerospace Medicine

MEDICAL EXAMINATIONS AND STANDARDS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Air Force Policy Directive (AFPD) 48-1, *Aerospace Medicine Enterprise,* AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation* and Department of Defense (DoD) Directive, 1332.18, *Separation or Retirement for Physical Disability*, and DoD Instruction 6130.03, *Medical Standards for Appointment, Enlistment and Induction*. It establishes procedures, requirements, recording and medical standards for medical examinations given by the Air Force. It prescribes procedures and references the authority for retiring, discharging, or retaining members who, because of physical disability, are unfit to perform their duties. This instruction applies to all applicants for military service and scholarship programs. In addition to Active Duty (AD) personnel, this publication applies to Air Reserve Component (ARC), the Air Force Reserve (AFR) and the Air National Guard (ANG), and Air Force Pre-Trained Individual Manpower (PIM).

This instruction requires the collection and maintenance of information protected by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Authority to collect and maintain records prescribed in this AFI are outlined in Title 10, United States Code, Section 8013. Privacy Act System Notice F044 AFSG G, Aircrew Standards Case File, applies. This AFI may be supplemented at any level, but all supplements that directly implement this Instruction must be routed to AF/SG3P for coordination prior to certification and approval. Requests for waivers must be submitted through chain of command to the OPR listed above for consideration and approval. In accordance with AFI 33-360, *Publications and Forms Management*, requests for waivers must be submitted through the chain of command to the appropriate Tier waiver approval authority. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual (AFMAN) 33-363, *Management of Records,* and disposed of in accordance with the *Air Force Records Disposition Schedule (RDS) located in the Air Force Records Information Management System*

(AFRIMS). Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847s from the field through the appropriate functional chain of command. **Attachment 1** is a list of references and supporting information. This publication has been substantially revised and requires complete review.

SUMMARY OF CHANGES

This instruction has been substantially revised and must be completed reviewed. Major changes include the creation of a medical standards directory, clarification of applicable standards for retention and for Air Force civilian employees flying military aircraft, and the inclusion of instructions for identifying tier waiver authorities as approved by the Inspector General Advisory Board (IGAB).

Chapter 1

GENERAL INFORMATION AND ADMINISTRATIVE PROCEDURES

Section 1A—Medical Standards

1.1. Medical Standards. Medical standards and medical examination requirements ensure accession and retention of members who are medically acceptable for military duty. Specific medical standards are listed within the medical standards directory table. Please see AFI 44-170, *Preventive Health Assessment* and Physical Examination Techniques for further information.

1.1.1. **These standards apply to:**

1.1.1.1. Applicants for enlistment, commission and training in the Air Force and Air Reserve Component (ARC), United States Air Force Academy (USAFA), Air Force Reserve Officer Training Corps (AFROTC) (scholarship and non-scholarship), and the Uniformed Services University of Health Sciences (USUHS).

1.1.1.2. ARC and Health Professions Scholarship Program (HPSP) personnel entering AD with the Regular Air Force, unless otherwise specified in other directives.

1.1.1.3. Military members ordered by appropriate Air Force authority to participate in frequent and regular aerial flights or other Special Operational Duty (SOD) as described elsewhere in this instruction.

1.1.1.4. Members of all components on extended active duty (EAD) not excluded by other directives.

1.1.1.5. Members not on EAD but eligible under applicable instructions.

1.1.1.6. Members of the USAF PIM activated for mobilization exercises and/or actual contingency/wartime operations.

Section 1B—Medical Examinations

1.2. Medical Examinations. There are various types of medical examinations: Accession, Department of Defense Medical Examination Review Board (DODMERB), Initial Flying, Preventive Health Assessment (PHA), Flying, Retirement, and Separation. As long as all requirements are met, a medical examination may serve more than one purpose. Each is conducted and recorded according to the format and procedures prescribed in Aerospace Medicine Information Management System (ASIMS), AFJI 36-2018, *Medical Examination of Applicants for United States Service Academies, Reserve Officer Training corps (ROTC) Scholarship Programs, Including 2 and 3 Year College Scholarship Programs (CSP), and the Uniformed Services University of the Health Sciences (USUHS),* and Physical Examination Techniques. **Note**: Enlisted flying criteria are guided by the AFSC Career Field Manager at AF/A3. All induction physical examinations accomplished overseas by a medical treatment facility must be submitted through Physical Examination Processing Program (PEPP) to Air Education and Training Command (AETC)/SGPS (T-1). AETC/SGPS is the certifying authority for all accession physicals not done at a Military Entrance Processing Stations (MEPS) facility and for individuals undergoing Basic Military Training School (BMTS). ARC/SG is the

certification and waiver authority for all initial enlistment, commissioning, Active Guard and Reserve (AGR) and Palace Chase packages. AFRC/SG delegates certification authority to the local medical unit for enlistment physicals that do not require a waiver.

1.2.1. **A medical examination is required for the following:**

1.2.1.1. Entrance into active military service, ARC, AFROTC, USAFA, and Officer Training School (OTS).

1.2.1.2. Entry into Flying or other SOD training.

1.2.1.2.1. Documents forwarded to certification/waiver authority will be electronically submitted (i.e., PEPP) unless specifically authorized by certification/waiver authority for circumstances in which PEPP and Aeromedical Information Management Waiver Tracking System (AIMWTS) are not utilized or available. (T-1) **Note:** All induction physical examinations accomplished overseas by a medical treatment facility must be submitted through PEPP to AETC/SGPS. (T-1) AETC/SGPS is the certifying authority for all accession physicals not done at a MEPS facility. ARC/SG is the reviewing and certification authority for all ARC enlistment and commissioning exams.

1.2.1.3. Termination of service when specified by **Chapter 7** of this instruction.

1.2.1.4. As required by AFI 44-170.

1.2.1.5. As required for General Officer Boards.

1.2.1.6. Enlisted members applying for commissioning may use their most current PHA and completed AF Form 422, *Notification of Air Force Member's Qualification Status*, noting qualified for General Military Service (GMS), Commission and Retention without a deployment limitation, in lieu of accomplishing another physical for the specific purpose of commissioning.

1.2.2. **Examiners:** All personnel prior to entrance into the military service will have an examination completed by either DoDMERB contracted personnel or MEPS. For all other examinations, the following personnel can complete the required examination.

1.2.2.1. A credentialed physician employed by the armed services, regardless of AD status, to include TRICARE providers and United States Coast Guard (USCG) credentialed providers, as well as designated Air Force physician assistants, (Air Force Specialty Code (AFSC) 42G4X) or primary care nurse practitioners (AFSC 46NXC), under the supervision of, and subject to review by a physician, may accomplish non-flying medical examinations.

1.2.2.2. A credentialed military or USCG flight surgeon (FS) with current/active privileges in flight/aerospace medicine will perform medical examinations on Air Force flying and/or SOD personnel. (T-1)

1.2.2.2.1. When the exam is accomplished by a non-Air Force FS at a location where no AF FS is available, forward the documents (including PHA and clinical documentation, labs, AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty*, or DoD equivalent, AF Form 469, *Duty Limiting Condition Report*, etc.) to the examinee's servicing military treatment facility (MTF) for review

and MAJCOM/SG for review and certification. This includes aircrew on joint/ North Atlantic Treaty Organization (NATO) tours, etc.

1.2.2.2.2. When the exam is accomplished by a non-AF FS at a joint base or AF MTF, the AF FS must ensure sister-service FS is trained in AF standards and associated paperwork. Training will be determined by the SGP and documented in the Provider Activity Folder. If trained, sister-service FS can sign AF Form 1042 or DoD equivalent without an AF FS review. Quality control will be assessed via FS peer review IAW AFI 44-119, *Medical Quality Operations*. If untrained, an AF FS must review all PHA and return to flying status (RTFS) documentation for AF aircrew. All aircrew and SOD members examined by a US military FS (to include USCG FS) and found qualified to perform flight or SOD will be returned to flying/SOD status upon completion of their examination.

1.2.2.2.3. Military flight surgeons must be credentialed and privileged in flight/aerospace medicine at the examining facility and can be of any branch of the military service or Coast Guard. All may make aeromedical dispositions (RTFS) if credentialed as noted.

1.2.2.2.4. Physicians who are Air Force civilian employees or contractors may perform medical examinations on AF flying and/or SOD personnel and be credentialed to make aeromedical dispositions only if they meet the qualification criteria listed in the Civilian Flight Medicine Physician Performance Work Statement located at **https://kx.afms.mil/kxweb/dotmil/file/web/ctb_207539.pdf** and approved by Air Force Medical Operations Agency (AFMOA)/SGPF.

1.2.2.3. NGB/SG may delegate review and certification authority to current, trained and designated State Air Surgeon (SAS) on certain initial Flying Class (FC) III and return to FCIII examinations, Commission/Enlistment physicals not requiring MAJCOM level waiver and on Active Guard Reserve (AGR) Title 32 physicals. **Note:** Consult current Tri-Service agreements and MAJCOM/SG prior to forwarding examinations.

1.2.2.3.1. State Air Surgeon that are current, certified, and trained as specifically identified by NGB/SG retain this authority. This authority will not be delegated further. At locations where SAS are not assigned, or are not trained, the certification/waiver authority reverts to NGB/SG.

1.2.3. **Locations.** Physical examinations are normally accomplished at the following locations:

1.2.3.1. Medical facilities of the uniformed services, including TRICARE facilities and Reserve Health Readiness Program (RHRP) () providers away from an MTF.

1.2.3.2. MEPS.

1.2.3.3. DODMERB contract sites.

1.2.3.4. Where no AF or DoD MTF exists, TRICARE Service agreement providers may accomplish examinations. This may include credentialed providers for military attaché and embassy members.

1.2.3.5. Air Force Medical Support Agency (AFMSA) AFMSA/SG3PF must authorize exceptions to the above. Exceptions to the above for Temporary Disability Retirement

List (TDRL) examinations require HQ Air Force Personnel Center (AFPC)/DPMADS approval.

1.2.3.6. Hospitalization of civilian applicants in military or government hospitals is authorized only when medical qualification for military service or flying training cannot be determined without hospital study and only after authorization by the Medical Group Commander. **Note:** Except as stated above, civilian applicants are not eligible for health care in DoD facilities unless they are an authorized beneficiary.

1.2.3.6.1. If additional testing is required to determine accession eligibility for non-beneficiaries and if the services are available, the Air Force may authorize testing to be accomplished at MTFs or other government agencies.

1.2.3.6.2. In the event a diagnosis or potential diagnosis of disease is noted during an examination, the examining provider will counsel the applicant and effect transfer of care to the member's private physician. (T-0) Treatment is not authorized for non-beneficiary applicants; however, every effort to secure positive transfer of care is mandatory in this instance. (T-0)

1.2.4. **Required Baseline Tests and Sample Collections:**

1.2.4.1. Blood type and Rh factor.

1.2.4.2. Glucose-6-Phosphate Dehydrogenase (G6PD).

1.2.4.2.1. All service members initially identified with a G6PD deficiency require medical education in a face-to-face visit documented in the medical record.

1.2.4.3. Hemoglobin-S. Confirm positive results with electrophoresis.

1.2.4.3.1. All service members initially identified with confirmed positive result require medical education in a face-to-face visit documented in the medical record.

1.2.4.4. Human Immunodeficiency Virus (HIV) Antibody. Consult AFI 48-135, *Human Immunodeficiency Virus Program* for additional details.

1.2.4.5. Color Vision Testing: Pseudoisochromatic Plate (PIP) testing to determine color vision perception which will be completed at accession and results recorded in their record. If an applicant wants to apply for flying or special duty, then they must pass the Cone Contrast Test (CCT) at an AF MTF or equivalent. (T-1) **Exception**: See **3.1.3** for applicants for Initial Flying Class I and IFCII/FS and Remotely Piloted Aircraft (RPA) duties.

1.2.4.6. DNA Specimen Collection, for Genetic Deoxyribonucleic Acid Analysis sample storage.

1.2.4.7. Urine Drug Screen (UDS). See DoDI 1010.16, *Technical Procedures for the Military Personnel Drug Abuse Testing Program (MPDATP).* **Note:** Overseas applicants excluding Alaska, Hawaii, and Puerto Rico can get their UDS screening within 72 hours after arriving at their first training base. Overseas MTFs must note on the DD Form 2808, *Report of Medical Examination* that the test was not done, and must be completed upon arrival at their first training location/base. (T-0) See US Code, Title 10, Subtitle A, Part II, Chap 49, section 978. and AFI 44-120, *Military Drug Demand Reduction Program*.

1.2.5. **Testing Locations.** The above tests must be accomplished at the MEPS with the exception of DNA and UDS. If tests are not completed at MEPS, accomplish at the following locations:

1.2.5.1. Air Force non-prior service recruits at Lackland AFB, Texas, during basic training.

1.2.5.2. Basic Officer Training (BOT) students at Maxwell AFB, Alabama, during OTS training.

1.2.5.3. Commissioned Officer Training (COT) students at their first permanent duty station.

1.2.5.4. USAFA cadets will be tested at USAFA.

1.2.5.5. All other entrants (e.g. AFROTC, prior service enlisted recruits and AF PIM Airmen) at their entry point or first permanent duty station.

1.2.5.6. Enlistment physicals for ANG/AFRC candidates must be accomplished at MEPS, and must be completed before submission to ANG/AFRC units. Certification and Waiver authority remains as described in **Attachment 2.** **Note:** See US Code, Title 10, Subtitle A, Part II, Chap 49, section 978 and AFI 44-120.

1.2.6. **Records Transmittal.** Transmit reports of medical examination and supporting documents that contain sensitive medical data IAW AFI 41-210, *TRICARE Operations and Patient Administration Functions* and system of records notice FO 44 SG E, Medical Record System and HIPAA guidelines.

1.2.7. **Disorders of substance abuse or dependence.** Disorders of substance abuse or dependence receive duty restrictions IAW AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*.

1.2.8. **Disorders That Are Unsuiting.** Disorders that are unsuiting for or interfere with military service are managed administratively through the patient's chain of command IAW AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers* and AFI 36-3208, *Administrative Separation of Airmen*. Unsuiting disorders must not be confused with disorders that determine a member unfit for duty and potentially are entered into the disability evaluation system (DES) IAW DoDI 1332.38, *Physical Disability Evaluation*.

Section 1C—Medical Examination/Assessment/MISC--Accomplishment and Recordings

1.3. Medical History. If the patient's health record contains a completed SF 93, *Report of Medical History* or DD Form 2807-1, *Report of Medical History*, and the individual acknowledges that the information is current and correct; do not accomplish a new form.

1.3.1. **Report of Medical History required updates.** The report of medical history is to be updated when medical examinations are accomplished for the following purposes:

1.3.1.1. Entry into active military service.

1.3.1.2. Appointment or enlistment in the Air Force or Air Reserve Component.

1.3.1.3. Retirement or separation from active military service as specified by this instruction.

1.3.1.4. Whenever an examination is sent for higher authority review.

1.3.1.5. Whenever considered necessary by the examining health care provider; for example, after a significant illness or injury or commander directed physical assessment.

1.3.1.6. Examination of an ARC member. For ANG flying and non-flying PHAs, accomplish a AF Web Health Assessment (WEB HA) in place of updated DD Form 2807-1.

1.3.1.7. Lost medical records. Accomplish a PHA with a detailed medical history.

1.3.2. **Interval Medical History.** Once a complete medical history has been recorded on a SF 93 or DD Form 2807-1, only significant items of medical history since the last medical examination are recorded. This is called the interval medical history. Reference each update to the medical history with the current date, followed by any significant items of medical history since last examination. ANG will use AF WEB HA for interval history.

1.3.2.1. Changes in Flight Status. Any significant medical condition requiring hospitalization, excusal, grounding for greater than 30 cumulative days for same or similar conditions, profile change or suspension from flying status is recorded as part of the interval medical history. The information concerning the interval medical history is obtained by questioning the examinee and by a thorough review of the examinee's health records.

1.3.2.2. Significant Medical History. Use SF 93/DD Form 2807-1, waiver requests, Medical Evaluation Board (MEB) diagnosis, or restricted duty for 30 days or more as a guide in determining items to include as significant medical history. Do not record "routine" items such as URIs, viral illnesses, etc., unless hospitalization was required or the illness is of a frequent or chronic nature.

1.3.2.3. Denial Statement. After recording the interval medical history, the following denial statement is recorded: "No other significant medical or surgical history to report since last examination (enter the date of that examination in parentheses)."

1.3.2.4. No Interval Medical History Statement. If the examinee had no interval medical history, record the current date followed by the statement: "Examinee denies and review of outpatient medical record fails to reveal any significant interval medical or surgical history to report since last examination dated (enter the date of that examination in parentheses)." See physical examination techniques for denial statement used when accomplishing the DD Form 2807-1.

1.3.2.5. Additional Space. Use SF 507, *Clinical Record-Continuation Sheet* as an attachment to the Report of Medical History when additional space is required (See Physical Examinations Techniques).

1.4. Medical Examinations. The results of medical examinations are recorded on DD Form 2808 or approved substitutes in accordance with physical examination techniques.

1.5. Adaptability Rating. Adaptability Rating for Military Aviation (ARMA) and other military duties, such as for Marine Diving Duty (MDD), Ground Based Controller (GBC), RPA or Missile Operations Duty (MOD) etc., is the responsibility of the examining flight surgeon, as is the scope and extent of the interview. Initial (entry into training) unsatisfactory adaptability ratings are usually rendered for poor motivation for aerial or SOD adaptability, or evidence of a

potential safety of flight risk, etc. (see Medical Standards Directory and Physical Examination Techniques.

1.6. DD Form 2766*, Adult Preventive and Chronic Care Flowsheet*. DD Form 2766 is used to record results of tests such as blood type, G6PD, DNA, Flyer/SOD ground testing, flying/SOD waiver information, etc., and also may be used as a deployment document IAW AFI 10-403, *Deployment, Planning and Execution*.

Chapter 2

RESPONSIBILITIES

Section 2A—Responsibilities

2.1. Air Force Surgeon General (HQ AF/SG). Establishes medical standards and examination policy.

2.1.1. AF/SG is the certification and waiver authority for Air Force-specific medical standards.

2.1.2. AF/SG may delegate waiver authority in writing to AF/SG3, AF/SG3P, AFMSA/SG3 or AFMSA/SG3PF. Other delegation of certification or waiver authority is only as designated in this instruction.

2.2. AFMSA/SG3PF.

2.2.1. AFMSA/SG3PF may delegate waiver authority to MAJCOM/SG level or lower IAW **Attachment 2**. The delegation may be in this instruction or a separate delegation letter located on the Knowledge Exchange (KX).

2.3. MAJCOM/SG.

2.3.1. Delegates in writing the Aerospace Medicine Specialist/s waiver authority at the MAJCOM IAW **6.4.2.1**

2.3.2. MAJCOM/SG or delegated authority in **2.3.1**

2.3.2.1. Delegates in writing the local base Aerospace Medicine Specialist or Flight Surgeon who is authorized to act as waiver and certification for designated exams/conditions IAW **6.4.3**

2.3.2.2. Liaison between MTF, medical squadrons, or medical groups and AFMSA/AFMOA.

2.4. Medical Treatment Facility, Medical Squadron, or Medical Group Commander.

2.4.1. Ensures timely scheduling and appropriate completion of required examinations and consultations. Unless adequately explained delays are documented, examinations should be completed not more than 30 days after appointment with Flight Surgeon unless adequate explanation of delay is documented. (T-1)

2.4.2. Ensures medical documents are filed in the health record and a completed copy filed IAW AFI 41-210.

2.5. ANG SAS.

2.5.1. ANG SAS serves as local Aeromedical certification/waiver authority for selected initial and trained flying personnel when so designated by NGB/SG IAW **Attachment 2**.

2.6. Chief of Aerospace Medicine (SGP).

2.6.1. Applies medical standards IAW AFI 48-101, *Aerospace Medicine Enterprise*, AFI 48-149, *Flight and Operational Medicine Program (FOMP)*, AFI 10-203, *Duty Limiting Conditions*, and AFI 44-170.

2.6.2. Reports to MTF/CC and/or MAJCOM/SGP any limitations to appointment access and completion of Initial Flying Class Examinations in a timely fashion. (T-1)

2.6.3. Coordinates with SGH, FHM, and Medical Standards Management Element (MSME) to ensure clear process exists for deployment medical waivers and that it is briefed to Professional Staff annually. (T-2)

2.6.4. Coordinates annual Professional Staff Briefing with SGH regarding provider responsibilities within this instruction. (T-2)

2.6.5. Serves as the local aeromedical certification and waiver authority when so designated by Attachment 2 and MAJCOM/SG or delegate written appointment. (T-1)

2.6.6. Serves as the installation subject matter expert on medical standards and physical qualifications. The SGP is the installation focal point in handling matters of medical standards application and resolving problems associated with conducting assessments, documentation and required follow-up of complicated or sensitive cases, and other matters that may call for resolution. (T-2)

2.7. Primary Care Elements (to include Flight Medicine).

2.7.1. During each encounter, review ASIMS status and determine qualification for retention, and deployment qualification IAW **Chapter 5**, Medical Standards Directory and **Chapter 11**. (T-2)

2.7.1.1. Ensure ASIMS is updated upon every encounter.

2.7.1.2. All providers must determine if the reason for the current encounter affects deployment, retention qualification, and whether the member needs to be placed on a Duty Limiting Condition (DLC) profile as described in AFI 10-203, *Duty Limiting Conditions*.

2.7.2. Completes PHA IAW AFI 44-170.

2.7.3. Refer to DoDI 5210.42-R, *Nuclear Weapon Personnel Reliability Program (PRP)*, to determine applicable PRP procedures.

2.7.4. Initiate and complete any Review in Lieu of (RILO)/MEB required for continued service for empanelled personnel. (T-0)

2.7.5. Non-flight medicine Primary Care Elements complete professional and paraprofessional clinical aspects of non-flying exams and/or assessments, to include those studies necessary to determine fitness for various clearances, special duty assignment profiling actions, overseas assignments, medical evaluation boards, retraining, transfer to ARC etc. Flight Medicine retains consultant oversight/management of the Occupational Medicine (OM) aspect of the exams/assessments unless there is a stand-alone OM clinic. (T-2)

2.7.5.1. Complete additional clinical consultations or follow-ups to finalize physicals, assessments and/or clearances to include all types of examinations no matter who performs initial examination.

2.7.6. Flight and Operational Medicine Responsibilities: Complete all professional, paraprofessional, and clinical components of flying and SOD exams. (T-1) In addition, completes occupational health exams and/or assessments unless separate OM Clinic is located at the MTF. (T-2) Clinical follow-ups for flying and SOD personnel are the responsibility of the Flight Medicine Primary Care Manager (PCM) team; this includes interim waiver evaluations as requested in AIMWTS. (T-1) Interim evaluations must be performed and tracked by the FM PCM team or health systems technician for the ANG. (T-2

2.7.6.1. Ensures each member of flight medicine subscribes to the Knowledge Junction of AFMSA/SG3PF Aerospace Medicine.

2.7.6.2. Ensure an effective grounding management program is maintained.

2.7.6.3. Initiate, track, and conduct follow up/interim evaluations or studies for all flying and SOD waivers, to include entry into AIMWTS and any RILO required for continued service.

2.7.6.4. Flight surgeons are responsible for all required aeromedical summaries.

2.7.6.5. Flight surgeons will act as OM consultants for all PCM teams. If the MTF/CC has appointed an OM physician that is not a FS, that physician will provide primary OM consultant services with support from flight surgeons.

2.7.6.6. Serves as the initial point of contact for scheduling of non-enrolled examinees, AFROTC, OTS applicants and ARC members requiring flying/SOD examination requirements. Identifies any required physical examination documentation and data entry, and assists with scheduling exams for all non-enrolled patients requiring flying/SOD physical examinations.

2.8. Public Health (Force Health Management (FHM) Element) or equivalent.

2.8.1. Is charged with the administrative oversight of ASIMS IAW AFI 48-101. Ensures each member of FHM is subscribed to the Knowledge Junction of AFMSA/SG3PF Aerospace Medicine. (T-2)

2.8.2. Keeps Primary Care Elements, medical facility executive leadership, unit health monitors, unit deployment managers, and unit/installation leadership informed of ASIMS (to include PHA, Individual Medical Readiness (IMR), Occupational Health Examinations, and Immunizations) requirements and current status for all AD and assigned civilian employees (as applicable). (T-1)

2.8.3. Performs all requirements IAW AFI 44-170.

2.8.4. Manages and performs all Occupational Hearing Conservation audiograms (except at bases where separate Occupational Medicine Services (OMS) are already established outside of PH) IAW Air Force Occupational Safety and Health (AFOSH) Standard 48-20. At bases with a separate OMS facility, PH manning for occupational audiograms will be part of OMS. **Note**: For Air Force Reserves, the Reserve Medical Unit Wing Medical Support work center

is the equivalent element responsible for accomplishing deliverables outlined in paragraph **2.8** for AFRC members. (T-1)

2.9. MSME or equivalent.

2.9.1. Ensures initial flying/SOD physical exams are completed in a timely manner (should be less than 30 days for non-waiverable initial flying class/SOD exams; measured from date of examination to date sent to certification authority in PEPP). Completion rates and issues impacting completion are reported to SGP every month, or local MTF (RMU) leadership. (T-2)

2.9.2. Ensures training is completed for all PEPP and AIMWTS users for documentation of physical examination and waiver actions. (T-1)

2.9.3. Ensure mechanism for scheduling or schedules initial flying class/SOD examinations for all enrolled and non-enrolled personnel who require initial flying class/SOD examinations. (T-1)

2.9.4. Fulfills roles as outlined in AFI 48-149, AFI 10-203, AFI 44-170 and AFI 41-210.

2.10. Member's Commander. Ensures the member is available for and completes examination including required follow-up studies for final disposition. (T-2) Ensures medical and occupational restrictions are relayed to supervisors without revealing sensitive information. (T-2)

2.11. Member's Supervisor. Actively supports this AFI and coordinates with MTF personnel to ensure completion of required examinations and follow-up testing of their subordinates. (T-2) The supervisor is encouraged to implement recommended temporary medical and occupational restrictions until removed or restrictions expire. (T-2) **Note:** ANG coordinates with MDG Personnel and ensures member follows up with Civilian Primary Care Manager for care as needed. (T-2)

2.12. Member. Meets scheduled medical appointments as directed. (T-2) Member should inform unit supervisor of required follow-up evaluations and appointments. Reports and submits all medical/dental treatment obtained through civilian sources and any medical condition that might impact utilization and readiness of personnel to the assigned Primary Care Element team or ARC medical unit. (T-1) See **Chapter 10** for additional guidance regarding ARC members.

Chapter 3

TERM OF VALIDITY OF MEDICAL EXAMINATIONS

Section 3A—Term of Validity

3.1. Administrative Validity. Reports of medical examination are considered administratively valid as follows:

3.1.1. Enlistment. Physical examination is within 24 months of date of entry on active or ARC duty. **Note**: A physical examination for accession accomplished by MEPS is valid for two years regardless of certification date. The validity is based on the date of examination versus date of certification.

3.1.2. Commission:

3.1.2.1. The USAFA entrance physical may be utilized as the commissioning physical with the following additions: The cadet's medical condition must not have changed significantly since the entrance physical; all laboratory tests for DNA, HIV and drug/alcohol tests must have been accomplished during the cadet's tenure; a DD Form 2807-1 must be completed prior to commission; a focused medical examination must be performed if clinically indicated. Initial flying or SOD physicals must still be performed in their entirety. (T-1)

3.1.2.1.1. Air Force Academy. Physical examination is medically certified/waived within 24 months of date of entry into the Academy.

3.1.2.2. Civilian applicants. Physical examination is within 24 months of date of entry on to active or ARC duty. **Not**e: A physical examination for accession accomplished by MEPS is valid for two years regardless of certification date. The validity is based on the date of examination versus date of certification.

3.1.2.3. Entry into Professional Officers Course (POC), AFROTC, USUHS, or HPSP scholarship. Physical examination is medically certified/waived within 24 months of date of entry into the program.

3.1.2.4. AFROTC, HPSP, Air Force Academy program graduates: commissioning physical examination is valid for 48 months from the date certified.

3.1.2.5. ARC members. Applicants accessed into the ARC from any service component must provide a current AF Form 422 or equivalent (within six months) to include PULHES, current DD Form 2697, *Report of Medical Assessment* and their last PHA.

3.1.2.5.1. Change in commission status for applicants for the Reserve program will be certified by ARC/SG, regardless of break in service.

3.1.2.6. AD service members who are applying for commission must have a current PHA. ARC members applying for commission must have a current PHA.

3.1.2.7. Certification for Reserves for AGR tours is the Reserve Medical Unit. Delegation of this certification authority is extended only to those Reserve Medical units responsible for providing physical exam support.

3.1.2.8. ARC/SG is waiver authority for all Regular AF members entering the ARC. Before Regular AF members will be considered for waiver for the ARC, all disqualifying defects must be appropriately evaluated for Fitness For Duty (FFD) IAW **Chapter 5**, Medical Standards Directory. Waiver by the AD authority does not guarantee waiver for AF Reserve duty.

3.1.2.9. The appropriate ARC/SG, or delegated authority, is the certification/waiver authority for AGR tour applicants not meeting standards in **Chapter 5**, Medical Standards Directory; or **Chapter 6**, **Section 6G**; MAJCOM level tours; and AGR tours with no supporting ARC medical unit.

3.1.3. **Flying Training.** Undergraduate Flying Training (UFT) includes all variants of Specialized Undergraduate Pilot Training (SUPT), Combat Systems Operator , Undergraduate Air Battle Manager Training (UABMT) and Undergraduate Remotely Piloted Aircraft Training (URT) training. Undergraduate Pilot Training (UPT) refers to applicants for pilot (manned). Examination (Flying Classes I and IA) must be current within 48 months prior to starting UPT/UNT. Examination (Flying Classes II) must be current within 48 months prior to starting URT. The 48 month period begins from date of certification/waiver of the physical examination (e.g. AETC/SGPS certifies examination on 1 Jan 2008. The 48 month period expires 1 Jan 2012.). Medical history (DD Form 2807-1) must be verified as current within 12 months prior to start of training. Service member must have a current PHA in addition to certified IFCI/IA. An initial certification examination does not exempt service applicants from accomplishing their required PHA while awaiting training. **Note:** If a member has an IFCI/IA examination and later applies for a flying or SOD duty that does not have to meet IFCI/IA standards, the IFCI/IA examination is valid for four years and no supplement is needed.

3.1.3.1. UPT applicants must meet Flying Class I standards to be eligible for entry into the Medical Flight Screening (MFS) program. URT pilot applicants must meet IFC II standards to be eligible for Medical Flight Screening-Neuropsychiatric (MFS-N) screening. Currently rated RPA applicants who previously completed MFS in conjunction with IFC I/IA and are in active flying assignments must meet IFC II standards but do not require repeat MFS-N screening.

3.1.3.2. All initial applications for UPT must pass MFS prior to beginning UPT.

3.1.3.3. All initial applications for URT must pass MFS-N prior to beginning URT. MFS for RPA pilot applicants will be limited to conditions requiring further evaluation (MFS-N is mandatory and may include enhanced MFS-N screening if appropriate).

3.1.3.4. Pilot and Navigator candidates must have a current, certified Flying Class I/IA examination, respectively, on record. AETC/SGPS will retain waiver authority for UPT/UNT students from successful completion of an IFC physical and MFS, until they graduate from UPT and are awarded a pilot AFSC. **Note**: While attending UPT/UNT training FCI/IA standards (as appropriate) apply. Upon UPT graduation FCII standards apply.

3.1.3.5. Flight surgeon and URT applicants must have a current, certified IFCII examination on record and be qualified for FCII duties while attending training and upon graduation.

3.1.3.6. The member's PHA should be current prior to beginning active UPT/URT. If a member was not on AD (e.g. AFROTC/OTS candidates) prior to arrival at UPT/URT or is otherwise not PHA current, then member will have PHA accomplished during in-processing at the UPT/URT base. PHA currency must be maintained throughout UPT/URT. See AFI 44-170 for additional details.

3.1.4. **Continued Flying.** Flying and Special Duty Operations personnel will follow existing guidance in AFI 44-170. Required examinations for these personnel are in sync with current PHA and IMR reporting business rules. The initial flying/SOD physical may also count as the commissioning physical as long as all requirements of the commissioning physical are met.

3.1.5. **Inactive Flyers.** Inactive flyers that do not receive aviation pay IAW AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Aviation Badges* are not required to maintain Flying Class II standards as outlined in **Chapter 6**, and the Medical Standards Directory. Inactive Career Enlisted Aviators and Special Operator Duty (SOD) personnel that do not receive aviation pay IAW AFI 11-402 are not required to maintain their appropriate standards as outlined in **Chapter 6**, Medical Standards Directory. A flight surgeon may complete aeromedical waivers for inactive flyers or SOD if member intends to return to active status IAW **Chapter 6,** Medical Standards Directory. See **6.8.6** for additional details.

3.1.6. **Individuals selected to attend UPT and currently assigned to a non-rated position pending UPT report date.** If the start of UPT will be more than 48 months from the date of the certification of the original flying class I or IA physical examination, a new flying class I or IA exam will be required with certification by HQ AETC/SGPS. The requirements outlined in paragraph **3.1.3** and its sub-paragraphs apply.

3.1.7. Individuals selected to attend URT and currently assigned to a non-rated position pending URT report date. If the start of URT will be more than 48 months from the date of the certification of the original flying class II physical examination, a new flying class II exam will be required with certification by HQ AETC/SGPS. The requirements outlined in **paragraph 3.1.3** and its sub-paragraphs apply.

3.1.8. **Return-or entry (from ARC) to-AD Programs:**

3.1.8.1. Rated Recall Applicants: Participants in a Voluntary Rated Recall Program must meet IFCII/III standards and retention standards as appropriate to crew positions. Document the appropriate flying class physical in PEPP, and if a waiver is required, submit through AIMWTS. AETC/SG for AD is the enlistment/commissioning accession authority. See **Attachment 2, Table A2.1** for certification/waiver authority.

3.1.8.1.1. IFC physical is not required if the applicant separated from AD within 6 calendar months. Their last PHA must be valid through the date of re-entry or a new IFCII/III physical will be required.

3.1.8.2. Airmen entering AD following a break in service, must have an initial enlistment/commissioning/aviation (if appropriate) physical examination documented in PEPP if they have been off AD or incurred a break in service for more than 6 months. If they have been off AD for less than six months, a current/valid PHA is required. If aviation waiver is required, submit through AIMWTS. AETC/SG is the

enlistment/commissioning accession authority for AD. **Note**: See **5.2.2** and **Attachment 2, Table A2.1**

3.1.8.3. Airmen entering AD following ARC tours, must have an initial enlistment/commissioning/aviation (if appropriate) physical examination documented in PEPP if they have incurred a break in service for more than 6 months. If their break in service is less than six months, a copy of a current/valid PHA and a current AF Form 422 that reflects WWQ must be attached in PEPP. Examining facility will also complete the demographics tab in PEPP and the signature tab and forward to AETC/SG. If aviation waiver is required, submit through AIMWTS. AETC/SG is the enlistment/commissioning accession authority. **Note**: See **5.2.2** and **Attachment 2, Table A2.1**

3.1.9. **All other initial examinations.** All other initial examinations, including Flying Class III, Flying Class II (flight surgeon duties and RPA pilot), SOD, GBC, RPA Sensor Operator (1U0X1), and MOD are valid for 48 months from date of certification/waiver. If the certified physical examination will expire during formal technical training, the examination may be extended by the local SGP until completion of formal training. See AFI 44-170 for PHA examinations. (T-2)

3.1.10. **Non-rated applicants for flying duty (Class III)**, who are currently medically qualified and performing flying duty, do not require additional review and certification or reexamination unless the individual is applying for Inflight Refueling Duty, Survival, Evasion, Resistance, and Escape (SERE) Specialist, Combat Control Duty, Pararescue Duty, Combat Rescue Officer (CRO), or the individual is on a medical waiver. The current examination and/or waiver is valid through its expiration date.

3.1.10.1. For those on a medical waiver a renewal must be submitted to HQ AETC/SGPS through AIMWTS with the most recent flying PHA with full medical history. (T-1) Based on review by HQ AETC/SGPS a full physical may be required.

3.1.11. **PHA's.** General Officers, Aircrew, SOD, ARC Personnel, AD personnel, and Operational Support Flyers. PHA is valid as specified in AFI 44-170. AF/SG or delegated authority as dictated by mission requirements may extend the PHA expiration (See AFI 44-170).

3.1.12. **PHA less than 12 months.** ARC members ordered to EAD with the regular AF do not need a physical examination since they need only meet standards in **Chapter 5**, Medical Standards Directory. Most recent PHA can be used for determining suitability to be mobilized.

3.1.13. **Interservice transfers.** Interservice transfers of officers to the United States Air Force and the United States Air Force Reserve must be IAW AFI 36-2004, *Interservice Transfer of Officers to the United Air Force (USAF) and to the United States Air Force Reserve (USAFR).*

Chapter 4

APPOINTMENT, ENLISTMENT, AND INDUCTION

Section 4A—Medical Standards for Appointment, Enlistment, and Induction

4.1. References. DoDI 6130.03, *Medical Standards for Appointment, Enlistment or Induction in the Military Services,* **http://www.dtic.mil/whs/directives/corres/pdf/613003p.pdf**, establishes basic medical standards for enlistment, appointment, and induction into the Armed Forces of the United States according to the authority contained in Title 10, United States Code, Section 113. DoDI 6130.03. sets forth the medical conditions and physical defects that are causes for rejection for military service. These standards are not all inclusive and other diseases or defects can be cause for rejection based upon the medical judgment of the examining healthcare provider.

4.1.1. Personnel rejected for military service for any medical condition or physical defect listed in DoDI 6130.03 may be reviewed if the condition has resolved and a history of the condition is not disqualifying IAW this AFI.

4.1.2. DoDI 6130.03. directs utilization of the International Classification of Disease (ICD) in all records pertaining to a medical condition that results in a personnel action, such as separation or medical waiver. In addition, when a medical condition standard is waived or results in a separation, written clarification of the personnel action must be provided using standard medical terminology.

4.1.3. In accordance with DODI 1308.03, *DoD Physical Fitness and Body Fat Programs Procedures*, weight and height remain part of accession physical standards. See **Chapter 6**, and the Medical Standards Directory for additional requirements for flying applicants.

4.2. Applicability. These standards apply to:

4.2.1. Applicants for appointment as commissioned officers in the Active and Reserve components who have not held a prior commission for at least 6 months or it has been more than 6 months since separation.

4.2.2. Applicants for enlistment in the regular Air Force. Includes medical conditions or physical defects predating original enlistment, for the first six months of AD in the regular Air Force.

4.2.3. Applicants for enlistment in the Reserve or Air National Guard. For medical conditions or physical defects predating original enlistment (existing prior to service (EPTS)), these standards apply during the enlistee's initial period of AD for training until their return to their Reserve Component Units.

4.2.4. Applicants for reenlistment in Regular Air Force and ARC after a period of more than 6 months have elapsed since separation.

4.2.5. Applicants for the Scholarship or Advanced Course ROTC, and all other Armed Forces special officer personnel procurement programs.

4.2.6. Retention of cadets at the United States Air Force Academy and students enrolled in the ROTC scholarship programs.

4.2.7. AFROTC graduates whose AD is delayed under applicable directives.

4.2.8. All individuals being inducted into the Armed Forces.

4.2.9. Individuals on TDRL who have been found fit upon reevaluation and wish to return to AD. The prior disabling defect or defects, and any other physical defects identified before placement on the TDRL that would not have prevented reenlistment, are exempt from this directive. **Note:** Individuals on TDRL are considered "retired" and thus have left AD, (most likely for a period of at least 6 months before their first re-examination as a TDRL designated member), and therefore, fall under accession standards prior to re-entering military service.

Chapter 5

CONTINUED MILITARY SERVICE (RETENTION STANDARDS)

Section 5A—Medical Evaluation

5.1. Medical Evaluation for Continued Military Service (Retention Standards). This chapter and the Medical Standards Directory include medical conditions and defects that are potentially disqualifying and/or preclude continued military service. These standards are not all inclusive and other diseases or defects can be cause for rejection based upon the medical judgment of the examining healthcare provider. Airmen with conditions listed in this chapter and the Medical Standards Directory require evaluation for continued military service (See paragraph **5.3**). Other physical and mental conditions that render an individual unsuited for duty or otherwise interfere with military service do not constitute a physical disability. These conditions are not eligible for DES processing. See AFI 36-3208, para 5.11 and AFI 36-3212 for further instructions.

5.1.1. **For AD.** Potentially disqualifying medical conditions and defects are reviewed by the Deployment Availability Working Group (DAWG) IAW AFI 10-203 and AFI 41-210.

5.1.2. **For ARC.** Potentially disqualifying defects must first be determined if the condition is in the Line of Duty IAW AFI 36-2910, *Line of Duty (Misconduct) Determination*. If defects are found to be In Line of Duty, processing occurs through the AD process in paragraph **5.1.1** of this AFI. Potentially disqualifying defects that are not In Line of Duty require a fitness for duty evaluation and must be accomplished through the respective ARC/SG. All medical conditions and defects are reviewed by the Deployment Availability Working Group (DAWG), IAW AFI 10-203.

5.2. Applicability. The retention standards apply to:

5.2.1. Regular Air Force members on AD, unless excluded from DES by applicable directives (e.g. Punitive actions).

5.2.1.1. USAFA Cadets' retention standards for continued training at the Academy are the accession medical standards IAW DoDI 6130.03. If a USAFA Cadet has their accession medical standard waived, retention medical standards apply for that condition IAW 48-123 Chapter 5 and the Medical Standards Directory. If the Cadet does not meet accession standards and they are not waived, then Cadet is subject to DES processing in accordance with 10 U.S.C. § 1217 and AFI 36-3212.

5.2.2. All individuals who have separated or retired from AD with any of the regular Armed Services, but who are reenlisting in the regular Air Force or ARC when no more than 6 months have elapsed between separation and reenlistment. If more than 6 months have elapsed **Chapter 4** applies.

5.2.3. ARC and retired regular members if mobilized or otherwise recalled to AD.

5.2.4. ARC members who are:

5.2.4.1. On EAD unless excluded from disability evaluation by applicable directives.

5.2.4.2. Ordered to EAD with the regular Air Force and who are eligible for fitness for duty evaluation under applicable directives.

5.2.4.3. Reenlisting in the regular Air Force when no more than 6 months have elapsed between release from EAD with any regular Armed Service and reenlistment or entry. If more than 6 months have elapsed **Chapter 4** applies.

5.2.4.4. Not on EAD but eligible for MEB under applicable directives.

5.2.4.5. AFRC members entering AGR tours. ANG members entering EAD statutory tours (Title 10) or AGR tours (Title 32).

5.2.5. **Air Reserve Components.** The appropriate ARC/SG IAW **Attachment 2** uses the standards in **Chapter 5**, Medical Standards Directory, and the list of allowable prescribed medications to determine:

5.2.5.1. The medical qualification for continued military duty in the ARC for members not on EAD and not eligible for disability processing.

5.2.5.2. The medical qualification of officers and enlisted members from any service component requesting entrance into USAFR and ANG.

5.2.5.2.1. The medical qualification of officers and enlisted members from any service component requesting entrance into the ANG provided no more than 6 months have elapsed between separation from the service component and entry into the ANG.

5.2.5.2.2. If more than 6 months (from date of separation) have elapsed, applicants must meet the standards of **Chapter 4**

Section 5B—Medical Standards for Continued Military Service (Retention Standards)

5.3. Standards. While this is not an all-inclusive list of disqualifying conditions, conditions and defects listed in **Chapter 5** and the Medical Standards Directory are potentially disqualifying and/or preclude continued military service. The standards and other diseases or defects not specifically listed can be cause for rejection based upon the medical judgment of the examining physician or reviewing authority. Retention standards also require members to be fit for mobility status IAW **Chapter 11**. For AD Airmen and ARC Airmen with duty-related (line-of-duty-yes conditions), refer members with disqualifying conditions to the DAWG. For I/RILO and MEB processing, see AFI 41-210 and **5.3.2** For ARC members with non-duty-related (line-of-duty-no) refer members with disqualifying conditions to the DAWG for Fitness for Duty evaluation, see **Chapter 10**. For Airmen returning to AD who do not meet retention standards but are eligible for an assignment limitation code, AETC/SG will coordinate with AFPC/DPANM through evaluation for Assignment Limitation Code C (ALC-C) for potential assignment restrictions. While elective surgery by itself is not necessarily disqualifying, intentional effects and unintended complications from elective surgery may render an individual unfit for WWD. For elective surgery information, refer to AFI 44-102, *Medical Care Management*. In addition, non-emergent elective surgeries within 6 months of separation or retirement must have additional prior approval by HQ AFPC/DPAMM, as required IAW AFI 41-210.

5.3.1. **General and Miscellaneous Conditions and Defects.**

5.3.1.1. The individual is precluded from a reasonable fulfillment of the purpose of his or her employment in the military service.

5.3.1.2. The individual's health or well-being would be compromised if he or she were to remain in the military service. This includes, but is not limited to: dependence on medications or other treatments requiring frequent clinical monitoring, special handling or severe dietary restrictions.

5.3.1.3. The individual's retention in the military service would prejudice the best interests of the government. Questionable cases are referred to AFPC/DPANM or to the appropriate ARC/SG for those ARC members who are not on EAD and are not authorized disability processing.

5.3.1.4. The individual has an EPTS defect/condition which requires surgery, but the residuals of surgery may affect his/her retainability. In such cases, surgery may not be done until the expected results have been evaluated via I/RILO or MEB, and the member has been returned to duty.

5.3.1.5. Individuals requiring exemption from one or more components of the fitness test for greater than one year do not require I/RILO or MEB unless the underlying condition or limitation does not meet retention or deployment standards.

5.3.1.6. The individual's travel by military air transportation is precluded for medical reasons.

5.3.1.7. The individual has an assignment, TDY or deployment canceled due to a medical condition. Present case to the DAWG within 10 calendar days IAW AFI 41-210. The DAWG will evaluate if member meets retention medical standards or if deployment limiting condition will resolve within 365 days. If not, the DAWG must refer cases to AFPC/DPANM, AFRC/SGP or ANG/SGP. (T-1)

5.3.1.8. The individual continues to have a mobility limiting condition 1 year (cumulatively) after the defect became limiting and has not yet met an I/RILO/MEB or Fitness for Duty (FFD).

5.3.1.9. The individual has been hospitalized 90 calendar days and return to duty within 3 more months is not expected. I/RILO or FFD should be sent to AFPC/DPANM or appropriate ARC/SGP as determined by the DAWG.

5.3.1.10. The individual refuses required medical, surgical, or dental treatment or diagnostic procedures and the condition renders them not qualified for retention and/or mobility.

5.3.1.11. The individual requires determination of his or her competency for pay purposes.

5.3.1.12. The individual has had a sanity determination required by the Manual for Courts-Martial and the psychiatric findings indicate the member's fitness for continued military service is questionable.

5.3.1.13. The individual has coexisting medical defects that are thought to be the primary cause of unacceptable behavior or unsatisfactory performance.

5.3.1.14. A commander can refer a service member's case to the DAWG through the DAWG Chair or PEBLO, if a commander feels an individual's medical or mental health condition causes sufficient absence from duty that it interferes with mission accomplishment, poor duty performance and/or deployment concerns.

5.3.2. **The following conditions require I/RILO or FFD initiation within 90 days of diagnosis:** All members with organ failure requiring transplant or extensive medical treatment, brain injury with significant permanent physical or cognitive impairment, psychosis, bipolar or other mental health condition that will likely significantly impact member's ability to perform AFSC duties long-term, amputation of a limb, burns greater than 20% of body surface area (other than first degree) or resulting in loss of function or inability to wear personal protective equipment, blindness (bilateral, not just single eye), any terminal illness, seizure disorder, Acquired Immune Deficiency Syndrome (not just HIV positive), neoplastic diseases (a diagnosis of cancer or neoplastic disease may require additional time to establish a clear prognosis, will require lengthy treatment, or will be unable to perform his/her job for a protracted period of time), insulin dependent diabetes, and any other potentially career-ending condition. See AFI 41-210 for additional guidance.

5.3.3. **General Conditions That Interfere With Military Service.**

5.3.3.1. Certain conditions render an individual unsuited for duty, rather than unfit, and are subject to administrative separation since these conditions may interfere with military service. These conditions cannot be entered into the Integrated Disability Evaluation System (IDES). Consult AFI 36-3208 and DoDI 1332.38 for details and specific cases.

5.3.3.2. If a service member has a history of anaphylaxis and/or severe reactions requiring venom immunotherapy, although unsuiting conditions, the service member will require an I/RILO or FFD for ALC-C consideration if retained and not administratively separated. (T-1)

Chapter 6

FLYING AND SPECIAL OPERATIONAL DUTY

Section 6A—Medical Examination for Flying and Special Operational Duty (SOD)

6.1. Flying and SOD Examinations.

6.1.1. Medical Classifications. All Air Force or ARC applicants requesting an Air Force flying or SOD physical examination must process through an Air Force MTF, ARC MDG, or MFS (as applicable) to have their physical examinations/waivers processed. (T-1) All of these physicals will be processed using PEPP and AIMWTS if a waiver is required. (T-1) Any exception to accomplishing these exams at facilities other than Air Force facilities must be coordinated with AETC/SGPS. ARC FCIII applicants may be processed through the ARC medical unit. **Note**: Additional instructions on how to complete initial sister service flying or special duty examinations see the Sister Service Examination page on the Knowledge Exchange.

6.1.1.1. Flying Class I qualifies for selection into MFS, and once MFS is passed, commencement of UPT.

6.1.1.2. Flying Class IA qualifies for selection and commencement of Undergraduate Navigator Training (UNT) and initial medical qualification for 12SX Special Operations Combat Systems Officer.

6.1.1.3. Flying Class II qualifies:

6.1.1.3.1. For selection into URT and flight surgeon training.

6.1.1.3.2. Rated officers for continued flying duty (pilots, RPA pilots, navigators/electronic warfare officers, 12SX Special Operations Combat Systems Officer and flight surgeons).

6.1.1.4. Categorical Flying Class II qualifies rated officers for duty in certain restricted aircraft categories. Granting categorical waivers does not guarantee operational utilization. Restrictions for FCIIA, FCIIB, FCIIC, and FCIIU will be documented in the remarks section of the AF Form 1042 or DoD equivalent. (T-1)

6.1.1.4.1. Flying Class IIA qualifies rated officers for duty in low-G aircraft (e.g. tanker, transport, bomber, T-43, T-1).

6.1.1.4.2. Flying Class IIB qualifies rated officers for duty in non-ejection seat aircraft.

6.1.1.4.3. Flying Class IIC qualifies rated officers for aviation duty as specified in the remarks section of AF Form 1042 or DoD equivalent, as annotated on the DD Form 2808 or in AIMWTS. Example: Restricted to multi-place aircraft.

6.1.1.4.4. Flying Class IIU qualifies rated officers for duty as URT and RPA pilot duties only.

6.1.1.5. Flying Class III qualifies individuals for aviation as indicated in the Air Force Officer Classification Directory (AFOCD), and the Air Force Enlisted Classification

Directory (AFECD). USAFA cadets participating in USAFA cadet airmanship program, see **6.24.6**

6.1.1.6. SOD exams qualify individuals for duties in which aviation is not their primary function but they must meet standards as described in **Chapter 6** if indicated in the AFOCD or AFECD.

6.1.2. **Medical examinations are required when:**

6.1.2.1. Individual applies for initial flying duty (all classes).

6.1.2.2. Officers holding comparable status in other US military services apply for Air Force aeronautical ratings.

6.1.2.3. Personnel, including personnel of the ARC, are directed to participate in frequent and regular aerial flight as defined by AFI 11-401, *Aviation Management*. This includes civilian government employees as documented on the Position Description whom the hiring agent has determined must meet appropriate military flying/SOD medical standards.

6.1.2.4. Flying personnel, including personnel of the ARC, are suspended from flying status for 12 months or more for medical reasons and are applying for return to flying duties. For AD and ANG personnel use a PHA with AMS. For AFRC personnel use a DD Form 2808, DD Form 2807-1, and AMS for any disqualifying condition. **Note:** A complete initial qualification examination is not required.

6.1.2.5. Flying personnel are ordered to appear before a Flying Evaluation Board. Refer to AFI 11-402. For AD and ANG personnel use a PHA with AMS. For AFRC personnel use a DD Form 2808, and DD Form 2807-1. **Note:** Air sickness may be managed IAW AETCI 48-102, *Medical Management of Undergraduate Flying Training Students*. If there is no underlying medical pathology and patient remains unresponsive to the measures IAW AETCI 48-102, this becomes an administrative function.

6.1.2.6. Aviation service requalification. If the duration of medical disqualification was less than one year, the local flight surgeon clears the member for flying duty. If the duration of medical disqualification extended for at least one year but less than five years, forward to the gaining MAJCOM/SG, or HQ AFMSA/SG3PF as applicable for review and certification. If the duration of medical disqualification extended five years or longer, HQ AFMSA/SG3PF must certify for flying duty. All waivers forwarded to AFMSA must first go through the gaining MAJCOM/SG. Refer to AFI 11-402 for further information concerning aviation service requalification. See **6.4** for further information.

6.1.3. **Medical Evaluation Scope.**

6.1.3.1. Medical evaluations with scope to be determined by the examining flight surgeon are required when:

6.1.3.1.1. Flying personnel have been involved in an aircraft accident.

6.1.3.1.2. A commander or flight surgeon determines a member's medical qualifications for flying duty have changed.

6.1.3.1.3. For the following initial exams the examining flight surgeon handles disqualifying defects in the following manner:

6.1.3.1.3.1. Complete all Flying Class I and IA UFT, Initial Flying Class II (flight surgeon and RPA pilots), Initial Flying Class III, GBC, or MOD examinations, regardless of the nature of disqualifying defect. (T-1) Send completed DD Form 2808, applicable portions of the DD Form 2807-1, and all associated documents to the appropriate certifying authority or requesting agency. (T-1) The examining flight surgeon completely identifies, describes and documents the disqualifying defects and enters demographics and disqualifying diagnosis into PEPP and AIMWTS, include a brief AMS with pertinent information, signs, dates and forwards to certification/waiver authority as defined in **Attachment 2**. (T-2) These exams must not be disqualified at the base but must be completed as noted above and forwarded to the certification and waiver authority. (T-1) **Note**: At any point when the examining flight surgeon learns of a medical disqualification, including during medical record review or when obtaining a medical history, the flight surgeon must complete the minimum documentation as described above. (T-1)

6.1.3.1.3.2. Forward aeromedical disqualifications of untrained assets to AETC and of trained assets to the MAJCOM/SG for review and disposition. Local medical facilities do not have disqualification authority for medical cause.

6.1.3.1.3.3. Incomplete physical examinations or those where the individual no longer is pursuing a Flying/SOD physical, should have the reason for termination and/or the attempts by the MTF to ensure the individual completes the examination documented in PEPP. The MTF Aerospace Medicine Specialist may sign the certification tab to complete the PEPP entry after indicating the exam is incomplete and/or examination or individual no longer requires physical examination. Indicate on the certification that service member is qualified for retention and is not qualified for Flying/SOD secondary to incomplete examination or that individual no longer requires a physical examination

6.1.4. MAJCOM/SG will notify AFMSA/SG3PF of disqualified cases (rated pilots only). AFMSA/SG3PF will notify Federal Aviation Administration (FAA) of medical disqualification for rated pilots only.

Section 6B—Waiver Information

6.2. General Waiver Information. For applicants applying for initial flying (all classes) and SOD who are not currently already in the military, accessions and enlistments standards in **Chapter 4** and the Medical Standards Directory apply as well as appropriate flying/SOD standards for which they are applying. **Chapter 5** and the Medical Standards Directory apply to personnel serving as AD or ARC (e.g., AD SSgt applying for IFCI duty must meet retention standards and IFCI standards as reflected in the Medical Standards Directory, standards noted in **Chapter 5** and **Chapter 11** of this AFI.). The medical conditions listed in the Medical Standards Directory and **Chapter 11** are cause to reject an examinee for entry into any rated ,not-rated, or career enlisted aviator crew position training(all classes), or continued flying duty/SOD unless a waiver is granted. Additional information concerning aeromedical waivers can be found in the aircrew waiver guide. Acute medical problems, injuries, or their appropriate therapy are cause for withholding certification for entry into any rated ,not-rated, or career

enlisted aviator crew position training, or temporarily restricting the individual from flying until the problem is resolved, using AF Form 1042 or DoD equivalent. These standards are not all inclusive and other diseases, or defects, can be cause for rejection based upon the judgment of the examining flight surgeon. Any condition, that in the opinion of the flight surgeon presents a hazard to flying safety, the individual's health, or mission completion, is cause for temporary disqualification for flying duties.

6.2.1. **To be considered waiverable, any disqualifying condition must meet the following criteria:**

6.2.1.1. Not pose a risk of sudden incapacitation. (T-1)

6.2.1.2. Pose minimal potential for subtle performance decrement, particularly with regard to the higher senses. (T-1)

6.2.1.3. Be resolved or stable, and expected to remain so under the stresses of the aviation environment. (T-1)

6.2.1.4. If the possibility of progression or recurrence exists, the first symptoms or signs must be easily detectable and not pose a risk to the individual or the safety of others. (T-1)

6.2.1.5. Cannot require exotic tests, regular invasive procedures, or frequent absences to monitor for stability or progression. (T-1)

6.2.1.6. Must be compatible with the performance of sustained flying operations. (T-1)

6.3. Waiver of Medical Conditions. The individuals and organizations with authority to grant a waiver for medically disqualifying defects are listed in **6.4** and **Attachment 2**. Controversial or questionable cases, and cases that fall outside of the parameters set by this instruction and the Medical Standards Directory, will be referred to AFMSA/SG3PF at the discretion of the MAJCOMs.

6.3.1. **Term of Validity of Waivers.**

6.3.1.1. The waiver authority establishes the term of validity of waivers.

6.3.1.2. An expiration date is placed on a waiver for any conditions that may progress or require periodic reevaluation.

6.3.1.3. Waivers are valid for the specified condition. Any significant exacerbation of the condition, or other changes in the patient's medical status, automatically invalidates the waiver, and they are placed in Duties Not Including Flying/Controlling (DNIF/DNIC) status until the medical evaluation is complete, and a new waiver is requested and approved.

6.3.1.4. If a condition resolves and member is qualified by appropriate standards, or the condition no longer requires a medical waiver, and the individual has no other conditions requiring medical waiver, retire the waiver using AIMWTS with concurrence of waiver granting authority. (T-2) The individual who retires the waiver must annotate reason and MAJCOM point of contact who concurred (by name including the office symbol) in the "Reason for Retirement" block, before signing in AIMWTS. (T-1)

6.4. Waiver Authority.

6.4.1. **AFMSA/SG3PF retains waiver authority as follows:**

6.4.1.1. All initial and renewal categorical flying waivers; changes from one category to another; removal of a categorical restriction. Exceptions are for specific cases where AFMSA/SG3PF delegates to MAJCOM or in an official delegation letter from AFMSA/SG3PF (maintained on the KX). These cannot be further delegated to the base level.

6.4.1.2. All initial waivers in cases previously certified as medically disqualified by AFMSA/SG3P or MAJCOM/SG (rated officer or career enlisted aviator).

6.4.1.3. All initial waivers for conditions that do not meet retention standards listed in **Chapter 5**, and the Medical Standards Directory unless specifically delegated by AFMSA/SG3PF, this AFI, or other official delegation letter to the MAJCOM/SG.

6.4.1.4. All initial waivers for conditions referred to the Aeromedical Consultation Service (ACS), except as noted in official delegation letter from AFMSA/SG3PF and **6.4.1.4.1**

6.4.1.4.1. MAJCOM/SG may grant initial and may renew waivers for all routine ACS clinical management group evaluations as defined by the ACS, if the following two criteria are met: The aviator meets entry criteria into an established ACS clinical management/study group(s) and a waiver is recommended by the ACS. Controversial cases will be forwarded to AFMSA/SG3PF.

6.4.1.4.2. MAJCOM/SGs will not grant/renew waivers for members of active ACS study groups without consulting the ACS.

6.4.1.5. All cases where the ACS recommends medical disqualification regardless of waiver authority (rated only).

6.4.1.6. All flying class and SOD personnel's initial waivers for maintenance medication, except those listed in "Official Air Force Aerospace Medicine Approved Medications". See section **6I** for MOD personnel.

6.4.1.7. All flying waivers and disqualifications on general officers, regardless of diagnosis. AFMSA/SG3PF will forward a copy of any general officer categorical waiver action to: AF/DPG 1040 Air Force Pentagon, Washington DC 20330-1040. **Note**: ARC does not have a requirement to forward categorical waivers to AF/DPO or AF/DPG.

6.4.1.8. Any controversial condition that in the opinion of the MAJCOM/SG warrants an AFMSA/SG3P decision.

6.4.1.9. AFMSA retains certification/waiver authority for all color vision and depth perception deficiencies for all flying/SOD classes unless otherwise delegated. **Note**: Enlisted flying criteria are guided by the AFSC Career Field Manager at AF/A3.

6.4.1.10. AFMSA/SG3P retains waiver authority for all flying classes/SOD for immunodeficiency syndromes (primary or acquired) and confirmed presence of HIV or antibody.

6.4.1.11. If AFMSA/SG3P disqualifies a service member, then second waiver requests for previously disqualified conditions are considered on a case-by-case basis only, and waiver authority for these individuals is AFMSA/SG3P.

6.4.1.12. All cases where an active flight surgeon or candidate for flight surgeon does not meet FC II standards and is unable to obtain a FC II waiver.

6.4.1.13. In cases where no qualified Air Force flight surgeon is assigned to the Air Component Surgeon's office, or the waiver authority is uncertain, waiver authority is AFMSA/SG3P.

6.4.1.14. For cases in which AFMSA/SG3PF is waiver authority, interim waiver or waiver extension authority by subordinate commands is specifically denied unless specifically delegated by AFMSA/SG3PF for a specific case or in a delegation letter.

6.4.2. **MAJCOM retains waiver authority as follows:**

6.4.2.1. MAJCOM certification and waiver authority for flying and SOD medical standards may only be accomplished by a specialist in aerospace medicine. MAJCOM/SGs who are not an Aerospace Medicine Specialist (AFSC 48A) will delegate their authority to an Aerospace Medicine Specialist on their staff. If the MAJCOM/SG is an Aerospace Medicine Specialist (AFSC 48A), authority may be delegated to qualified Aerospace Medicine Specialists (AFSC 48A) on their staff. When MAJCOM/SG desires to delegate MAJCOM Aeromedical Waiver authority to a Senior Flight Physician who is not an Aerospace Medicine Specialist, a waiver can be requested by MAJCOM/SG from AFMSA/SG3PF for a Senior Flight Surgeon to be delegated as a MAJCOM Aeromedical Waiver Authority.

6.4.2.2. MAJCOM/SG or delegated authority may grant initial and renewal waivers for all routine ACS clinical management group evaluations as defined by this AFI.

6.4.2.2.1. If delegated to the MAJCOM, categorical waivers (except IIC for pregnancy) for grade below Colonel need a copy of the waiver action sent to AFPC/DPAOT3, 550 C Street West Ste 31, Randolph AFB, TX 78150. Categorical waivers (except IIC for pregnancy) for Colonel (0-6) need a copy of the waiver action sent to: AF/DPO 1040 Air Force Pentagon, Washington DC 20330-1040. All FCIIC waiver actions delegated to MAJCOM/SG require memorandum cover letter by MAJCOM/SG be forwarded to AF/SGE, Attn: AFMSA/SG3PF, 1780 Air Force Pentagon, Washington DC 20330-1780 and USAF/A3OT, 1480 AF Pentagon Washington, DC 20032-1480, to include FCIIC waiver renewals. Ensure the categorical restrictions are contained in the memorandum. **Note**: ARC does not have a requirement to forward FCIIA, FCIIB, FCIIC, and FCIIU waivers to AF/DPO or AF/DPG.

6.4.2.3. Medical waiver authority has been delegated to the MAJCOM to which the member is assigned for duty unless specifically noted in **6.4.1** For example a member's MAJCOM is ACC, but they are assigned Permanent change of Station (PCS) to USAFE. The gaining MAJCOM (USAFE) becomes the certification and waiver authority in accordance with **Table A2.1**. If the member belongs to a tenant unit of one MAJCOM and the tenant unit is on the base of another MAJCOM, then the medical waiver belongs to the tenant unit's MAJCOM. For example a C-21 pilot stationed at Keesler AFB (AETC) is a member of the AMC tenant unit located at Keesler AFB; AMC is the waiver authority for delegated conditions.

6.4.2.4. Responsibility for medical waivers has been delegated as follows: Air Force District of Washington (AFDW) is delegated to AMC/SGP. Others: Air Force Element (AFELM), Defense Intelligence Agency (DIA), Air Force Operational Test and Evaluation Center (AFOTEC), if not otherwise specified in **Table A2.1** will be the medical facility's MAJCOM/SG that submits the aeromedical waiver examination package. Waiver authority for Air Force Inspection Agency (AFIA) is delegated to AFIA/SG when that position is filled by an Aerospace Medicine Specialist (AFSC 48A). Medical waiver authority for personnel assigned to USSOCOM is delegated to AFSOC/SG. Medical waiver authority for personnel assigned to NORTHCOM is delegated to AFSPC/SG.

6.4.3. **Delegation of Waiver Authority for Flying and SOD Personnel:**

6.4.3.1. Command and USAFA surgeons may delegate waiver authority to another command surgeon or to a Residency Trained Aerospace Medicine specialist working on that MAJCOM staff (Aerospace Medicine Specialist (AFSC 48A), AFSC 48A3/48A4 or ARC 48R3/48R4). Exceptions will be approved by AFMSA/SG3P. Command surgeons IAW 2.3.3. may delegate base level (local) waiver authority to the installation Aerospace Medicine Specialist or most qualified Flight Surgeon, most likely the SGP. Waiver delegation will indicate authority based on residency trained Aerospace Medicine Specialist (Aerospace Medicine Specialist (AFSC 48A)) versus non Aerospace Medicine Specialist. **Note**: Authority to grant flying class III waivers to rated personnel who have been medically disqualified for flying class II is delegated to the member's MAJCOM/SG of assignment. See **6.4.1.11**

6.4.3.1.1. Local Base Certification/Waiver Authority (AD only). Flight surgeons as specifically identified by the MAJCOM of the member, normally the Chief of Aerospace Medicine (AFSC 48X3/4), retain this authority. (T-1) This authority will not be delegated further**.** (T-1) At locations with flight surgeons who do not meet this criteria, the certification/waiver authority reverts to the MAJCOM of assignment. Non-flight surgeons are not authorized to sign, or certify medical examinations. (T-1) Flight surgeons granted this authority by their MAJCOM may not certify/waiver ARC aircrew members. (T-1) **Note**: Limited scope MTFs may delegate to a supporting MTF's Senior Aeromedical Specialist with MAJCOM approval and delegation. (T-2)

6.4.3.2. Certification and waiver authority for assignment into ARC flying positions may not be delegated lower than MAJCOM/SG level unless authorized by ARC/SG.

6.4.3.2.1. Delegation of this certification authority is extended only to those Reserve Medical units responsible for providing physical exam support.

6.4.3.3. AD non-aircrew members transitioning into ARC flying positions must have their medical examinations certified by the appropriate ARC Surgeon.

6.4.3.4. Certification and waiver authority for USAF flying personnel while assigned to the National Aeronautics and Space Administration (NASA) is NASA.

6.4.3.5. AFMC/SG has certification and waiver authority on USAF Test Pilot School applicants and all USAF Flight Test Engineers (62E3F) and Development Engineers (61S), except as noted in **6.4.1** May be further delegated at AFMC/SG discretion.

6.4.3.6. AETC/SGPS is the certification and waiver authority for all ARC members entering AD in the regular Air Force. Before ARC members will be considered for waiver for AD in the regular Air Force, all disqualifying defects must be noted, reviewed, evaluated and waived by the ARC waiver authority. Waiver by the ARC authority does not guarantee waiver for regular Air Force duty.

6.4.4. **Centralized Flying Waiver Repository (AIMWTS).**

6.4.4.1. AIMWTS will serve as the centralized flying waiver repository.

6.4.4.2. All flying medical waiver actions will be recorded in AIMWTS.

6.4.4.3. Flying waivers that are no longer required due to personnel separation and/or retirement should be allowed to expire.

6.4.5. **Waivers for Enlisted Occupations.**

6.4.5.1. The medical service does not make recommendations for medical waivers for entry or retention in non-flying or SOD AFSCs for those who fall below qualification standards imposed by personnel directives. Any flying or special operational restrictions/limitations must comply with **6.4.1.9** Medical waivers will not be granted to allow an individual disqualified from one AFSC to enter another AFSC, when the defect is disqualifying for both AFSCs.

6.4.5.2. When requested, the medical service provides professional opinion to line or personnel authorities.

6.4.6. **Submission of Reports of Medical Examination to Certification or Waiver Authority.**

6.4.6.1. Initial certification, waiver requests and disqualification recommendations for all flying, MOD and SOD examinations will be submitted using PEPP and/or AIMWTS. Submissions to the reviewing/certification authority using PEPP and/or AIMWTS must be accomplished simultaneously (e.g. do not submit AIMWTS without submitting physical in PEPP if you accomplished one). Supporting documents must be uploaded as attachments into these applications and forwarded to the reviewing/certification authority. Do not accomplish DD Form 2808, or PHA solely for the purpose of a waiver submission unless flight surgeon deems necessary, or directed by higher authority. **Note:** PHA**,** SF 600, *Medical Record – Chronological Record of Medical Care*, or DD Form 2808 must be accomplished according to the frequency in AFI 44-170 and is irrespective of waiver action. (T-1)

6.4.6.2. All waiver requests referred to AFMSA/SG3P must be submitted through the MAJCOM/SG. (T-1) MAJCOM/SG must provide a recommendation on the case to AFMSA/SG3P through AIMWTS in the forwarding remarks. If a waiver requires an ACS evaluation or review, the MAJCOM/SG must request the ACS evaluation/review. The MAJCOM/SG will not forward to AFMSA/SG3P until the ACS evaluation/review results are completed and documented in AIMWTS. **Note:** In the case of unapproved medications, MAJCOM/SG will send to AFMSA/SG3P who will review and determine appropriate action.

6.4.6.3. All waiver requests must include as a minimum: (T-1)

6.4.6.3.1. Aeromedical Summary with other supporting documents pertinent to the case included as attachments within AIMWTS additional guidance can be found in the Aircrew Waiver guide. (T-1)

6.4.6.3.2. If available, include the results of DPANM adjudication, indicating the member has been returned to duty following I/RILO or MEB/ Physical Evaluation Board (PEB). (T-1)

6.4.6.3.3. All waiver cases submitted must include any pertinent medical documentation from the member's civilian health care provider. Examining flight surgeon will review this information and reference it in the aeromedical summary. (T-1)

6.4.7. **Routing of Dispositions:**

6.4.7.1. The certifying authority certifies the AMS in AIMWTS. Flight medicine ensures a printed or electronic copy of the certified AMS document is placed into the electronic or paper health record IAW current guidance in AFI 41-210.

6.4.7.1.1. Trained Assets: Flight Medicine prepares, files, and forwards the AF Form 1042 or DoD equivalent with appropriate remarks indicating a waiver or disqualification as appropriate.

6.4.7.1.2. Initial flying waivers: Flight Medicine provides member or their designated authorized representative a copy of their initial medical examination to include with their training request.

6.4.7.2. MAJCOM/SG notifies AFMSA/SG3PF of disqualifications on rated pilots. See **6.1.4** for further information.

6.4.7.3. If certified disqualified (trained asset): A flight surgeon will advise the member they are medically disqualified from their flying or SOD, and provide the member with the AF Form 422, for use in retraining actions with the Military Personnel Flight. (T-2) Document the notification of disqualification in the health record. The member's unit must also be notified of the member's disqualification from flying or SOD. (T-1) The AF Form 422, AF Form 1042 if required by Host Aviation Resource Management (HARM) or DoD equivalent may be used, with appropriate comments in the remarks section of the AF Form 1042 or DoD equivalent of the member's permanent disqualification from flying and SOD.

6.4.7.4. Repatriated Prisoners of War (RPW). MSME sends a copy of each medical examination (DD Form 2808, DD Form 2807-1, or DD Form 2697) to USAFSAM/FEC, 2947 Fifth Street Wright-Patterson AFB, OH 45433-7913, and to the Office of Special Studies, Naval Operational Medicine Institute (NOMI), Code 25, NAS Pensacola, FL 32508-5600. **Note:** Include "RPW" on Report of Medical History form, as an additional purpose for examination.

Section 6C—Medical Recommendation For Flying Or Special Operational Duty or DoD equivalent

6.5. Applicability. Applies to each Air Force MTF or ARC medical squadron/Group providing support for flying or SOD personnel. Use AF Form 1042 or DoD equivalent to convey updates

and changes to medical qualification for flying or SOD. Flying or SOD personnel are defined as any Air Force member with an ASC, AFSC or duty position that must meet special entry and continuing medical qualifications as defined in **6G**, **6H**, **6I**, and **6J**.

6.6. Authority to determine aeromedical dispositions. Non-flight surgeon medical providers may ground flying or SOD personnel via the AF Form 1042 or DoD equivalent. For all encounters with a non-FS, a DoD FS; must document review and aeromedical disposition of all non-flight surgeon medical providers' entries in the member's medical record. (T-1) A grounding AF Form 1042 or DoD equivalent initiated by a non-flight surgeon medical provider must be reviewed, countersigned and dated by the DoD FS, however, effective date will be the date issued. (T-1) Only a flight surgeon can return flying/SOD to flying/SOD or continue them on flying/SOD during/after a medical encounter IAW AFI 11-202V3, *General Flight Rules*. (T-1) **Exception**: HQ AF/SG delegates to the Medical Treatment Facility (MTF) Commander the authority to grant AFSOC Physician Assistants (PAs) working independently in support of Special Operations Command missions, aeromedical disposition privileges when deployed and without reasonable access to a FS preceptor, IAW AFI 48-149. (T-1)

6.6.1. Personnel on flying or SOD status who receive dental treatment will be managed IAW AFI 47-101, *Managing Air Force Dental Services.* Dental personnel will use AF Form 1418, *Recommendation for Flying or Special Operation Duty – Dental*, to notify the flight surgeon of recommended flying or special duty restrictions exceeding 8 hours. The reviewing flight surgeon should then initiate a DNIF via AF Form 1042 or DoD equivalent. (T-1) See AFI 47-101, Paragraph 6.16. for further details.

6.6.2. **Aeromedical Disposition of ARC Personnel On Air Sovereignty Alert (ASA), Total Force Initiative (TFI) units or Federal RPA missions.** ARC aviation personnel performing ASA, TFI, or operating large RPA systems in support of a Federal mission are eligible for AD grounding management (DNIF and RTFS) and care for acute medical conditions that if not addressed would negatively impact completion of that mission. **Note**: Routine medical care is not authorized and remains the responsibility of the Airman via his/her regular health care provider.

6.6.2.1. If a flight surgeon is not co-located with the flying operation, these aircrew may be seen by a non-flight surgeon health care provider (military or civilian). The aircrew must inform the provider that written or verbal communication of the details of the visit (including history, physical, and treatment provided) must be submitted to the appointed military flight surgeon immediately following the visit. (T-1) The flight surgeon may render an aeromedical disposition determination remotely if he/she has sufficient information, and after communicating both with the provider and the aircrew member. The flight surgeon must be confident that there has been sufficient resolution of symptoms and treatment side effects. (T-1) All relevant medical and medication standards still apply. Aeromedical disposition decision must be communicated immediately to the aircrew's unit. (T-1) The AF Form 1042 or DoD equivalent must be sent electronically to the aircrew's unit the morning of the next duty day. (T-1)

6.6.2.2. Aircrew and special duty personnel in locations not co-located with an AD base may be returned to flying status to perform alert, combat or National Air Defense duties when their unit flight surgeon is not available. These personnel may be returned to

flying/SOD status after being examined by a military or civilian physician via reach-back consultation with a military flight surgeon as designated by AFMSA/SGPF.

6.6.2.3. ANG or AFRC flight surgeons who maintain active credentials and privileges in Flight Medicine may use their Flight Medicine credentials to make aeromedical dispositions while employed in a civilian Flight Medicine physician role.

6.7. Prepare a new AF Form 1042 or DoD equivalent when an individual is:

6.7.1. Found temporarily medically unfit—described as DNIF, DNIC or Duties Not to Include Alert (DNIA).

6.7.2. Determined by a flight surgeon to be fit for RTFS or RTC/A (Return to Controling/Alert) for SOD.

6.7.3. Medically certified for flying by appropriate review authority following disqualification.

6.7.4. Medically certified for continued flying/SOD following medical examinations.

6.7.5. To temporarily "ground" or clear aircrew following involvement in any class of aircraft mishap.

6.7.6. To permanently medically disqualify a member for flying or SOD.

6.7.6.1. Only after MAJCOM or higher authority certifies examination in AIMWTS, permanent disqualification authority is the same for waiver actions as noted in **Attachment 2**. Also, refer to **6.1.3.1.3.2**. **Note:** An AF Form 1042 or DoD equivalent does not need to be accomplished with the expiration of a flying PHA. The HARM Office will take appropriate administrative action if a new AF Form 1042 or DoD equivalent is not received by the expiration date.

6.8. Form Completion:

6.8.1. AF Form 1042 or DoD equivalent must contain the date the individual is actually found certified. (T-1)

6.8.2. Date of the flight surgeon signature will serve as the date the action was accomplished. (T-1) For DNIF action signed by another provider the flight surgeon only needs to countersign the provider signature as the date the form was initiated needs to be the action date.

6.8.3. If the examination cannot be completed prior to expiration due to reasons beyond the member's control, and the patient has a flying medical waiver that will expire, the examining flight surgeon may request a waiver extension from the appropriate MAJCOM/SG. If granted, a new AF Form 1042 or DoD equivalent must be accomplished to reflect the extension and sent to the member's HARM Office as specified in this chapter. (T-1) **Note:** Only extensions in AIMWTS are authorized. If an extension to an existing waiver is warranted, waiver extension must be recorded in AIMWTS and a new waiver renewal initiated at base level. (T-1)

6.8.4. Flyers and SOD personnel unavailable for PHA secondary to deployment will follow guidance in AFI 44-170.

6.8.5. The remarks section of the AF Form 1042 or DoD equivalent can be used for local special purpose determinations, i.e., "May perform Supervisor of Flying duties," with the determination based upon the flight surgeon's assessment of the member's mental alertness and physical capabilities. The remarks section of the 1042 may also be used by FS to comment on Special Tactics/Combat Rescue operator dispositions regarding jump, dive, control status/clearance as determined by the credentialed FS (ie…may control/dive, continue DNIF). The Remarks section of any AF Form 1042 or DoD equivalent leaving the MTF will not have member's diagnosis or other protected health care information written or otherwise affixed in accordance with HIPAA rules. (T-0) Commanders must be advised to contact the flight surgeons office if more details about a member's condition are required.

6.8.6. Inactive Flyers. Do not complete DNIF or RTFS on an AF Form 1042 or DoD equivalent for individuals in inactive aviation service categories. The exceptions are for individuals who are collecting flight pay or plan to go back to active flying. Completion of the AF Form 1042 or DoD equivalent for these exceptions notifies ARMS that member completed their PHA, potential permanent disqualifying condition is recognized, or an aeromedical waiver may be required.

6.9. AF Form 1042 or DoD equivalent Distribution:

6.9.1. Original to patient's health record. For transient personnel, send the original and 2 copies to the individual's home MTF flight medicine clinic for distribution.

6.9.2. Grounding management communications with operational units and HARM offices must be treated as Protected Health Information (PHI). (T-0) Release of this information to operational units, commanders and HARM offices is allowed under DoD 6025.18-R, *DoD Health Information Privacy Regulation*. This release of PHI must be documented as an accountable disclosure IAW AFI 41-210, Section 6D.

6.9.2.1. The ASIMS database is currently installed with a HIPAA-compliant documentation log for any releases of PHI sent via email notification from within ASIMS. All such actions automatically generate an electronic log entry to document each release of PHI. This function includes e-mail notification to operational flying/SOD units and HARM offices regarding AF Form 1042 or DoD equivalent grounding management actions.

6.9.2.2. In addition to email notifications, a signed copy of the AF Form 1042 or DoD equivalent must still be provided to the HARM office for inclusion in the member's flight Record. This action constitutes its own release of PHI and must also be documented. To prevent unnecessary additional workload, the email notification template in the Grounding Management module of ASIMS states: "A signed copy of this grounding management action is also being forwarded to the HARM office for inclusion in the member's Flight Record Folder."

6.9.2.3. One copy to the local HARM Office (within 1 duty day) for flying/SOD personnel, or to the unit commander or supervisor for other personnel using the HIPAA compliant documentation log within the e-mail notification of the grounding management module.

6.9.2.4. One copy to the member's unit. **Note**: Flight medicine clinics maintain current and accurate unit and HARM office Point of Contact information in the email notification database as HIPAA requires the capability to identify all recipients of PHI.

6.9.2.5. One copy to the member.

6.9.2.6. Flying PHA performed by a non-AF flight surgeon requires review and certification by parent MAJCOM/SG if no AF flight surgeon is available at that location.

6.10. Disposition of Expired AF Form 1042 or DoD equivalent:

6.10.1. Grounding actions such as DNIF, DNIC, DNIA, dispose of when superseded by an AF Form 1042 or DoD equivalent for RTFS action.

6.10.2. Remove previous PHA clearances when superseded by a new PHA clearance AF Form 1042 or DoD equivalent.

6.10.3. Do not remove AF Form 1042 or DoD equivalent recording a member's RTFS following a period of DNIF, medical clearance post mishap or return to flight status from the outpatient medical record. These must remain a permanent part of a member's medical record. (T-1)

6.11. Record of Action. The flight surgeon office maintains a monthly log of restrictions and re-qualifications on AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log*, and disposes of AF Form 1041 as specified by Air Force Records Disposition Schedule. Use the AF Form 1041 log to track personnel who are in DNIF, DNIC, or DNIA status. AF Form 1041 is included within ASIMS.

6.12. General Officer Notification. The flight medicine PCM will notify their MAJCOM/SG or designee by telephone during duty hours when a general officer or wing commander is grounded. Reports will include: date of DNIF, aeronautical rating, ASC with AFSC, duty title and organization, diagnosis (es), estimated duration of DNIF (as applicable), and name and duty phone of attending flight surgeon. (T-2) Also, notify the MAJCOM/SG or designee when the GO or Wg/CC is RTFS. (T-2) **Note:** ANG does not require notification of the grounding of general officers or Wing Commanders.

6.13. Death Notification. The flight medicine PCM will notify their MAJCOM/SG or designee by telephone during duty hours when an aircrew or SOD member dies. (T-2) Reports will include: date of DNIF (as applicable), aeronautical rating, ASC with AFSC, duty title and organization, diagnosis (es), estimated duration of DNIF (as applicable), and name and duty phone of attending flight surgeon. (T-2)

Section 6D—Aeromedical Consultation Service (ACS)

6.14. General. The ACS conducts specialized aeromedical evaluations.

6.14.1. Eligibility Requirements**.** Persons eligible for referral to ACS include:

6.14.2. AD Air Force and ARC personnel on flying/SOD status, or as requested by the MAJCOM/SG or AFMSA/SG3P. Persons medically disqualified when approved by the MAJCOM/SG or AFMSA/SG3P.

6.14.3. Members of active ACS clinical management groups not on flying status (inactive flyers and disqualified members).

6.14.4. ACS evaluation appointments for 6J, 7J, 8J, and 9J aviators are invitational only, and are not mandatory medical evaluations (funding may be local or personal).

6.14.5. At the discretion of the MAJCOM/SG or AFMSA/SG3P, initial ACS evaluations of inactive flyers only if reassignment to active flying is pending.

6.14.6. Army and Navy personnel with approval of U.S. Army Aeromedical Center (USAAMC) Fort Rucker, AL, or NOMI, Pensacola, FL.

6.14.7. Coast Guard personnel with approval of CG Health, Safety, and Work-Life Service Center (HSWL-SC) Operational Medicine (OM), Norfolk, VA.

6.14.8. Military personnel of foreign countries when approved by the State Department and AFMSA/SG3P.

6.14.9. Applicants for flying duty with approval by HQ AETC/SG or AFMSA/SG3P.

6.14.10. Under special circumstances, astronauts may be given Secretarial Designee Status for ACS evaluation.

6.15. Referral Procedures.

6.15.1. Initial Evaluations: The referring flight surgeon prepares an aeromedical summary using AIMWTS. Once ACS evaluation is approved by either MAJCOM/SG or AFMSA/SG3PF, the ACS evaluation/review will be requested using AIMWTS. MAJCOMs will request the ACS evaluation and receive the results prior to submitting to AFMSA/SG3PF if AFMSA/SG3PF is the waiver authority. **Exception**: AFMSA will request the ACS evaluation if the waiver request is for an unapproved medication. **Note:** See waiver guide for information required for waiver submission. The appropriate mailing address is: U.S. Air Force School of Aerospace Medicine, 2510 5th Street, Bldg 840, Wright-Patterson AFB, OH 45433-7913.

6.15.2. Re-evaluations: These will be accomplished under the same guidelines as initial evaluations. Supporting documentation will be forwarded only at the request of the ACS. ACS re-evaluations will be coordinated with the MAJCOM/SG or AFMSA/SG3P, using AIMWTS.

6.16. Scheduling Procedures.

6.16.1. The ACS notifies the MTF of the appointment date and furnishes reporting instructions. The ACS will make every effort to schedule appointments as soon as possible after referral request. The ACS will only reschedule appointments due to mission essential reasons. Any requested documentation must be forwarded in sufficient time to reach the ACS 10 days prior to appointment. (T-2)

6.16.2. Members scheduled for ACS evaluations will be briefed by the referring local flight surgeon regarding ACS requirements and reporting instructions. (T-2) This responsibility may be delegated to MSME.

6.16.3. The MTF publishes the TDY orders and provides the funds to support the TDY (for ARC personnel, the member's squadron publishes orders and provides funds for the TDY).

6.16.4. The orders state that the TDY is for aeromedical evaluation and that 10 days, in addition to travel time, is authorized.

6.16.5. Send health records, by certified mail to arrive at the ACS 10 days before the scheduled appointment.

6.17. Consultation Procedures.

6.17.1. The ACS evaluates and makes recommendations to the waiver authority. The ACS is not a waiver authority.

6.17.2. The preliminary ACS report and recommendation patient status worksheet is sent electronically to the waiver authority within 3 workdays of the ACS date of recommendation. AIMWTS is updated with the ACS recommendation at this time.

6.17.3. If an in-person ACS evaluation is not required, the ACS will make recommendations via an aeromedical letter to the waiver authority and enter this into AIMWTS.

6.17.4. The final ACS report and recommendation patient status report (PSR) is sent electronically to the waiver authority within 60 workdays following member's departure. The ACS will also attach the PSR into AIMWTS.

Section 6E—Medical Flight Screening

6.18. Medical Flight Screening.

6.18.1. MFS is managed by the ACS and conducted at the ACS and the USAFA.

6.18.2. MFS uses additional advanced medical screening techniques (list of screening tests approved by AFMSA/SG3P and maintained at ACS) to ensure pilot candidates who have already passed their FCI physical are in compliance with standards described in this instruction and any superseding USAF policy. All UPT/URT applicants must complete and successfully pass MFS/MFS-N or receive a waiver prior to starting UPT/URT Pilot training.

6.18.3. Detailed information regarding MFS can be found on the KX).

Section 6F—USAF Aircrew Corrective Lenses

6.19. General USAF Aircrew Contact Lens Policy. Aircrew are authorized to use contact lenses (CLs) for vision correction provided they are in compliance with the requirements detailed in the USAF Aircrew Soft Contact Lens (ACSCL) Program. For complete program details on routine contact lens use, specialized contact lens use, and authorized contact lens solutions, refer to the AF Aircrew Contact Lens Program on the KX.

6.19.1. **ACSCL Applicability**. Adherence to this policy is required by:

6.19.1.1. Flying Class I/IA electing to wear contact lenses, on or off duty. (T-1)

6.19.1.2. Flying Classes II and III while performing aircrew duties. (T-1) **Note**: Flying Classes II and III electing to wear contact lenses off duty are not required to follow the ACSCL policy, but are highly encouraged to do so.

6.19.2. **Aeromedical Requirements for ACSCL Wear.** The member shall have no ocular, periocular or medical condition that would require or contraindicate SCL wear. Conditions

requiring use of contact lenses to obtain 20/20 vision in either eye not achievable with spectacles require an aeromedical waiver.

6.19.2.1. Visual acuities of 20/20 or better in each eye with current spectacles for both near and distant vision, immediately after removing SCL.

6.19.2.2. Visual acuities of 20/20 or better in each eye while wearing SCL for both near and distant vision. Bifocal spectacles used in combination with SCL to correct near vision to 20/20 are permitted.

6.19.2.3. Refractive astigmatism (at spectacle plane) of no greater than 2.00 diopters. Aircrew exceeding 2.00 diopters of astigmatism may be authorized to use SCLs but will require an aeromedical waiver.

6.20. Authorized Spectacle Frames for USAF Aircrew (USAF Aviation Spectacle Frame Program and AFI 11-202 V3). USAF military, civil service or USAF contracted aircrew personnel who wear spectacle based prescription eyewear (clear and/or sun protection) and/or spectacle based non-prescription sun protection are required to wear USAF approved eyewear while performing in flight duties. The USAF Aircrew Spectacle Frame Program defines and authorizes USAF aircrew eyewear. Authorized eyewear are identified under the Aircrew Flight Frame (AFF) series as the AFF-OP, AFF-DR (AFD), and AFF-JS (AFJ). No other spectacle frames are authorized for use in USAF aircraft by USAF aircrew or USAF contracted aircrew.

6.20.1. **Prescription Eyewear**

6.20.1.1. Local base optometry office is responsible for coordinating (prescribing, ordering, fitting, as required) spectacle-based vision correction for USAF aircrew. (T-1)

6.20.1.2. The DoD Optical Fabrication Enterprise will fabricate prescription clear and/or neutral density gray (N-15) sun protection as prescribed in an authorized AFF spectacle frame. (T-2) No other sun protection tint or spectacle frame is authorized for use in USAF aircraft by USAF military, civil service or contracted aircrew. The eye clinic will order the required spectacles through the DoD Optical Fabrication Enterprise in the same manner as other military eyewear orders through the Spectacle Request Transmission System (SRTS). (T-2) The eye clinic will fit and issue aviation spectacles to USAF military, civil service and contracted aircrew. (T-2) Eye clinics may also order AFF replacement parts (nose pads, temple screws, temples, etc) using MTF unit funds through the Electronic Catalog. (T-2)

6.20.1.3. USAF aircrew requiring prescription eyewear are authorized four sets of AFF spectacles per year, or as required. Two of these sets are fabricated with clear prescription lenses. The remaining two are fabricated as neutral density (gray) 15% transmission (N-15) sunglasses. Contractor aircrew requiring prescription eyewear are authorized two sets of AFF spectacles per year, one set with clear prescription lenses and one set with neutral density gray (N-15) sunglasses. USAF military, civil service or USAF contracted aircrew who use night vision goggles are also authorized an additional frame with polycarbonate lenses. These frames can be in any combination of the styles listed above.

6.20.2. Non-Prescription Eyewear:

6.20.2.1. Non-prescription AFF sun protection is obtained through local Individual Equipment Issue or equivalent supply office using member's unit funds.

6.20.2.2. Authorized non-prescription sun protection consists of an AFF series spectacle frame combined with neutral density gray (N-15) lenses. No other sun protection tint or spectacle frame is authorized for use in USAF aircraft by USAF aircrew or USAF contracted aircrew.

6.20.2.3. Aircrew not requiring prescription sun protective eyewear or who wear contact lenses for in-flight duties are authorized two sets of non-prescription sun protection eyewear (two pairs of spectacles) for flight duties.

6.20.2.4. Aircrew with defective color vision and a valid waiver may wear issued neutral density gray tinted sunglasses and laser eye protection when operationally authorized. However, aircrew with defective color vision are not authorized to wear the yellow high Contrast visor.

6.20.3. **Ballistic Eye Protection:** The Air Force Ballistic Protective Eyewear (BPE) Program manages the Air Force Protective Eyewear List (AFPEL) and provides implementation guidance. The Air Force adopted the Army's Authorized Protective Eyewear List (APEL). Products on the APEL have been evaluated by the Army Program Executive Office and found to meet or exceed military ballistic standards. AFPEL items are intended for ground use. Ballistic protection for authorized aircrew is found on the Flight Protective Eyewear List (FPEL). The AFF series frames are not equivalent to BPE. Flight ballistic protective eyewear (non-prescription spectacle/goggles) are obtained through local Aircrew Flight Equipment or equivalent supply office through the member's unit. Prescription inserts for FPEL items are ordered by the local optometry clinic through the SRTS ordering program. Current APEL and FPEL available at USAF Optometry Knowledge Junction / BPE: **https://www.kx.ams.mil/optometry** and USAF Flight Medicine Knowledge Junction / BPE: **https://www.kx.ams.mil/flightmedicine**. Aircrew BPE must be approved by the USAF Spectacle Frame Program (POC: USAFSAM/FECO). No other BPE is authorized for use by USAF aircrew.

6.20.4. **Aircrew Laser Eye Protection (ALEP): Prescription Requirements.** The flight medicine and ophthalmology/optometry clinics will ensure aircrew ALEP prescription accessory devices, when available, meet individual corrective vision specifications and are properly fitted per AFI 11-301v4, *Aircrew Laser Eye Protection (ALEP).* (T-2)

6.20.4.1. Prescription laser eye protection accessory devices are ordered through SRTS. For non- prescription aircrew laser eye protection refer to AFI 11-301v4 and **KX**.

6.20.5. **Refractive Surgery:** Corneal refractive surgery is authorized for eligible military personnel who request this surgery as part of the USAF Refractive Surgery Program. Complete details can be found on the KX. (T-2)

Section 6G—Medical Standards for Flying Duty

6.21. Medical Standards. For accessions and enlistments the standards in **Chapter 4** apply. **Chapter 5** and the Medical Standards Directory apply to personnel already serving as AD or ARC (example, AD SSgt applying for IFCI duty must meet retention standards in **Chapter 5**, as

well as IFCI standards in the Medical Standards Directory). For conditions listed in **Chapter 5** and the Medical Standards Directory, ensure an I/RILO or MEB has been initiated if appropriate.

6.21.1. All medical treatment obtained from any source must be cleared by a flight surgeon prior to reporting for flight duty and documented in the medical record. (T-1) When a crewmember receives care by a non-flight surgeon provider, the clinical encounter must be reviewed by a flight surgeon for appropriate aeromedical disposition prior to the member resuming flying duties. (T-1) Aircrew members must maintain a medical clearance from the flight surgeon to perform in-flight duties. (T-1)

6.21.2. All dental treatment obtained from any source other than trained military Dental Clinic personnel must be cleared by a flight surgeon prior to reporting for flight duty. (T-1) If a flight surgeon is not immediately available, the member will be removed from flying duties until seen by a flight surgeon or the visit has been reviewed by a flight surgeon. (T-1)

6.21.3. Use of any medication is prohibited, except as described in the "Official Air Force Aerospace Medicine Approved Medications" updated periodically by AFMSA (approved by AF/SG3P). (T-1) Use of any Over the Counter (OTC) Medications, except as described in the "Official Air Force Aerospace Medicine Approved Medications" and "Over the Counter (OTC) Medications," updated periodically by AFMSA (approved by AF/SG3P) is prohibited. (T-1) Dietary, herbal, and nutritional supplements can only be used with the approval of a flight surgeon. (T-1)

Section 6H—Ground Based Aircraft Controller

6.22. Ground Based Aircraft Controller Medical Standards. The standards in **Section 6H** and the Medical Standards Directory apply to all ground based aircraft controllers which includes air traffic controller, weapons controllers/directors, combat controllers and Command & Control Battle Management Ops (1C5X1), Tactical Air Control Party (1C4X1), Air Liaison Officer (13LX) and RPA sensor operators (1U0X1). Conditions in **Chapter 5** and the Medical Standards Directory or Worldwide Duty (WWD) standards also apply. For conditions listed in **Chapter 5** and the Medical Standards Directory, ensure an I/RILO or MEB has been initiated if appropriate.

6.22.1. In addition to the standards in **Section 6H** and the Medical Standards Directory for ground based control, Combat Controllers must also meet the standards for parachute duty (FCIII and relevant sister service school standards) and Medical Standards Directory standards. See Physical Exam Techniques and **6.24.1**

6.22.2. In addition to the standards in **Section 6H** and the Medical Standards Directory for ground based control, Air Battle Managers (13BX) and Air Weapons Controllers/Directors, required to perform frequent and regular aerial flights must also meet Flying Class III standards in **Section 6G** of this AFI.

6.22.3. The medical conditions listed in **Chapter 5,** Medical Standards Directory, and relevant **Section 6J** categories are cause to reject an examinee for initial controller duty or continued duty unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy are cause for withholding certification of initial training or temporarily restricting the individual from controller duties until the problem is resolved. These standards are not all inclusive, and other diseases, or defects, can be cause for rejection based

upon the medical judgment of the examining flight surgeon. Acute conditions which impair safe and effective performance of duty are cause for temporary removal from controlling duties using AF Form 1042 or DoD equivalent IAW **Section 6C**. **Note**: These standards do not apply to Small unmanned aircraft systems operators (SUAS-Os).

Section 6I—Missile Operations Duty (MOD) Standards

6.23. The medical conditions listed in Chapter 5, Medical Standards Directory, and Section 6I are cause to reject MOD personnel for initial accession in and continued missile operations (AFSC 13SXC) career field unless a waiver is granted. The certification authority for initial MOD examinations and waivers is AFGSC/SGP. For conditions listed in **Chapter 5**, ensure an I/RILO or MEB has been initiated if appropriate prior to the waiver request.

6.23.1. Acute medical problems, injuries, or their appropriate therapy can be cause for withholding certification for initial training or temporarily restrict the individual from MOD until the problem is resolved. These standards are not all-inclusive, and other diseases, or defects, are cause for rejection based upon the medical judgment of the examining flight surgeon. Acute conditions which impair safe and effective performance of duty are cause for temporary removal from MOD using AF Form 1042 or DoD equivalent IAW **Section 6C**.

6.23.2. Medication (See Approved MOD List on AFMSA Knowledge Junction).

6.23.2.1. Personnel may not perform Combat Mission Ready (CMR) or Basic Mission Capable (BMC) duties (AFGSCI 13-5301v3, *Rapid Execution and Combat Targeting (REACT) Crew Operations* paragraph 6.1.) while using any medication whose known common adverse effect or intended action(s) affect alertness, judgment, cognition, special sensory function, mood or coordination.(T-2) CMR and/or BMC personnel prescribed medication with these known common adverse effect or intended action(s) must be placed in DNIC or DNIA status while under their effects. (T-2) If chronic or long-term use of such medications is required, a medical waiver must be requested. Approval authority is the AFGSC/SGP. (T-2)

6.23.2.2. MOD personnel in non-CMR/BMC positions do not require DNIA/DNIC action for medications unless the underlying medical condition requires medical waiver action or the medication may affect alertness, judgment, cognition, special sensory function, mood or coordination and the medication use is anticipated as a long term maintenance medication. In such cases waiver work up and application is required before removal of the DNIA/DNIC action.

6.23.2.3. FDA-approved OTC medications and commercially available (in the United States) substances, to include herbal and nutritional supplements, may generally be used by MOD personnel without flight surgeon approval, provided the product is used in accordance with manufacturers' directions for its intended use and not in violation of Air Force policy.

6.23.2.3.1. MOD personnel are required to consult with the flight surgeon whenever: the member is within 12 hours of reporting for MOD and will be using the product for the very first time; or member experiences adverse reactions which may affect the member's ability to perform MOD.

Section 6J—Miscellaneous Categories

6.24. Requirements.

6.24.1. **Attendance at Sister Service Schools.** All personnel who require upgrade training or specialty training at sister services schools must meet any additional Sister Service medical requirements (which may be more restrictive). AETC/SGPS will initially certify these types of examinations to meet Air Force AFSC requirements, with the exception of static line (Airborne) not requiring a waiver which may be certified by the local aerospace medicine specialist as designated by the MAJCOM. Certification by AF does not guarantee Sister Service acceptance. Applicants must provide a copy of the AF exam to the medical staff of the sister service school with their application. (T-2)

6.24.1.1. Refer to US Army Regulation (AR) AR 40-501, *Standards of Medical Fitness* for most current requirements for attendance at Army schools. **Note**: See AF Physical Examination Techniques which contains AF and Sister Service requirements.

6.24.1.2. See *Manual of the Medical Department NAVMED P-117,* Article 15-102 for attendance at Navy schools. **Note**: See AF Physical Examination Techniques which contains AF and Sister Service requirements.

6.24.2. **Operational Support Flying (OSF) Duty.**

6.24.2.1. The conditions listed in **Chapter 5**, the Medical Standards Directory and this section are disqualifying for OSF personnel. Operational support applies to personnel fully qualified in non-aircrew specialties and required to temporarily perform duties of the specialty in-flight. OSF are required to occasionally fly. Since the member's primary full-time duties do not require him or her to be on board an aircraft, performance of in-flight duties is a special duty for the particular career field. Examples of operational support flyers are CCATT members.

6.24.2.2. Personnel who perform aviation duties as an OSF are required to have a normal examination of tympanic membranes, lungs and chest, heart, abdomen, neurologic, hemoglobin, weight, blood pressure and pulse documented in their health record for an initial examination. The exam’s expiration date is the PHA expiration date. **Note**: AF Form 1042 or DoD equivalent is issued as satisfactory evidence of completion of the requirements outlined for training and duty. This examination does not need to be entered into PEPP.

6.24.3. **Physiologic Training Participation**

6.24.3.1. Individuals must have the appropriate medical clearance to be eligible for physiological training (i.e. hypobaric chamber, reduced oxygen breathing device [ROBD] and/or centrifuge training). See AFI 11-403, *Aerospace Physiological Training Program* and/or AFI 11-404, *Centrifuge Training for High-G Aircrew* for additional information. See “Medical Standards Directory” for details on specific conditions which typically exclude trainees from physiological training (**https://kx.afms.mil/kxweb/dotmil/kjPage.do?cid=ctb_155907&functionalArea=AerospaceMedicine**).

6.24.3.2. Individuals with medical contraindications for hypobaric chamber training (e.g. history of neurological decompression sickness) must be directed toward normobaric

hypoxia training (e.g. ROBD) to meet AFI 11-202V1, *Aircrew Training*. If appropriate, AF Form 1042 should include statement "Hypobaric chamber training contraindicated; must meet AFI 11-202V1, requirements via normobaric hypoxia training". (T-1)

6.24.3.3. Documentation requirements. All clearances must have a specific expiration date ensuring the trainee is medically cleared through the duration of training.

6.24.3.3.1. US Military or Government Service Civilians. Copy of current AF Form 1042, , DA (Army) Form 4186, *Medical Recommendation for Flying Duty*, or Naval Medical Form 6410/2, *Clearance Notice (Aeromedical)*, indicating that a flying class I, II, or III physical has been completed.

6.24.3.3.2. Foreign Military. North Atlantic Treaty Organization (NATO) and other foreign military personnel may use the local base clearance or annual physical 1042 prepared by home station flight surgeons based on the standards of medical fitness for flying duties issued by the parent country IAW **Chapter 9** of this instruction. The supporting USAF flight surgeon(s) may provide medical clearances for "physiological training only" for foreign military personnel.

6.24.3.3.3. Service Academy/ROTC Cadets or Midshipmen. Same as **para 6.24.3.3.3.1** or evidence of medical clearance for hypobaric chamber training within previous 12 months prior to this training. The flight surgeon's office supporting the AOP Training Unit scheduled to provide this training must provide adequate oversight to ensure all cadets are medically qualified, to include clearing any current medical issues.

6.24.3.3.3.1. AF, Army, or Navy ROTC cadets will present evidence of satisfactory completion of DD Form 2808, or DD Form 2351, *DODMERB Report of Medical Examination*, accomplished within 48 months of the scheduled physiological training. **Note**: Before scheduling cadets for training, the ROTC detachment must send copies of the DD Form 2808, and DD Form 2807-1, or DD Form 2351, with DD Form 2492, *Report of Medical History to the Aerospace Physiology Unit*. The Aerospace Physiology Unit will have the local flight surgeon's office review these forms and stamp these documents "Qualified to Participate in Altitude Chamber Training" for all cadets physically qualified. AF Form 1042 or DoD equivalent, is not required for this group of trainees, but any current medical problems must be cleared by the local flight surgeon

6.24.3.3.4. Government Contractors, Non-DoD Government Civilians and Non-Government Civilians (to include DVs). Copy of current Federal Aviation Administration (FAA) Medical Certificate flying class I, II or III. The local flight surgeon should assist the AOP Training Unit CC in evaluating the medical suitability of any individual who does not appear to have the physical health commensurate with high-risk physiological training.

6.24.3.3.5. Civilians undergoing physiological training are required to present a current FAA medical certificate, or the forms listed in paragraph **6.24.3.3.3.1** or a valid AF Form 1042 or DoD equivalent.

6.24.3.4. Aerospace & Operational Physiology (AOP) personnel (AFSC 43AX and/or 4M0X1) are required to meet FCIII.

6.24.4. **Duty Requiring Use of Night Vision Goggles (NVG).**

6.24.4.1. Aircrew members and SOD personnel who wear NVGs in the performance of their duties are required to achieve at least 20/50 visual acuity with the NVGs in the pre-flight test lane. Aircrew who fail visual acuity standards for their flying class, complain of visual problems either with or without NVGs, or fail to achieve 20/50 visual acuity in the NVG pre-flight test lane must be referred for a clinical eye examination. The flight surgeon/PA must refer to AL-SR-1992-0002, *Night Vision Manual for Flight Surgeon*s, for additional guidance.

6.24.4.1.1. Personnel required to inspect, maintain or certify NVGs for use by Aircrew must possess visual acuity of at least 20/20 corrected or uncorrected in each eye. Prior to being assigned these duties, technicians will be referred for a routine clinical eye examination. Results will be documented in their medical records and re-certified annually as long as their duties include NVG inspection, maintenance, or certification. Technicians with visual acuity less than 20/20 will be issued spectacles IAW **6.24.4.2** to correct their vision. Technicians who cannot attain visual acuity of 20/20 corrected or uncorrected in each eye will be restricted from performing NVG inspection, maintenance or certification. (T-2)

6.24.4.2. Each aircrew or SOD member who requires corrective lenses in order to meet the visual acuity standards for flying, and who are required to wear NVGs in the performance of flying duties, are encouraged to wear soft contact lenses (SCL) with appropriate correction. Members who cannot, or do not wish to, wear SCLs are to wear industrial safety lenses (polycarbonate or 3.0 mm thick CR-39 plastic) when using NVG. Two pairs of aircrew spectacles with safety lenses ground to the appropriate correction can be obtained in the following manner:

6.24.4.2.1. If the individual has not had a refraction done within the past year, obtain a current refraction.

6.24.4.2.2. Order aviator spectacles using the current prescription through the local optometry clinic, or send the prescription using a DD Form 771, *Eyewear Prescription*, to the USAFSAM Aircrew Program Manager. Include verification of NVG duties statement when ordering the spectacles. See KX for further details.

6.24.4.2.3. Dispense the glasses to the individual with instructions to wear them only when using NVG and to protect the lenses from marring or scratching.

6.24.5. **Incentive and Orientation Flights.**

6.24.5.1. Incentive and Orientation Flights in Ejection Seat Aircraft.

6.24.5.1.1. All incentive and orientation flight candidates scheduled to fly in an ejection seat aircraft will be referred to the flight medicine clinic for a medical clearance prior to the flight. (T-1) A flight surgeon will accomplish a medical records review and a physical examination (scope of examination to be determined locally). (T-1) In lieu of medical record review, civilians must provide a statement of health from their physician to include a summary of medical problems and medications. All individuals (military and civilian) identified for incentive rides or orientation flights must be able to safely eject without unduly endangering life or limb. (T-1)

Communicate medical clearance and recommendations and/or restrictions to the flying unit on AF Form 1042 or DoD equivalent. This clearance will be valid for no longer than 14 days. **Note:** ARC clearances will be valid for no longer than 40 days. The following guidelines apply:

6.24.5.1.2. Signed parental consent is required if candidate is not on AD and under the age of 18.

6.24.5.1.3. Body weight, buttock-to-knee and sitting height measurements must be within minimums and maximums as specified in **Table 6.1 and associated references:**

Table 6.1. Anthropometric Standards For Incentive and Orientation Flights.

Airframe	Weight		Buttock-to-Knee Maximum	Sitting Height	
	Minimum	Maximum		Minimum	Maximum
B-1	140 lbs	211 lbs	27.0 inches	34.0 inches	40.0 inches
B-2	140 lbs	211 lbs	27.0 inches	34.0 inches	40.0 inches
B-52	132 lbs	201 lbs	27.0 inches	33.8 inches	40.0 inches
F-4	136 lbs	211 lbs	27.0 inches	34.0 inches	39.0 inches
F-15	140 lbs	211 lbs	26.2 inches	34.0 inches	40.0 inches
F-16	140 lbs	211 lbs	26.1 inches	34.0 inches	39.7 inches
T-6A	103 lbs	245 lbs	26.9 inches	31.0 inches	40.0 inches
T-37	132 lbs	201 lbs	26.3 inches	33.8 inches	40.0 inches
T-38 Northrop Ejection Seat	140 lbs	211 lbs	27.0 inches	33.8 inches	40.0 inches
U-2	132 lbs	201 lbs	26.0 inches	33.8 inches	40.0 inches

6.24.5.1.4. Individuals selected for incentive or orientation flights who do not meet anthropometric standards will be referred to the flying unit or wing commander (O-6 or above) for final authority disposition. (T-1) ACES-II ejection attempts above 340 KEAS (Knots Equivalent Air Speed) can result in increased injury risk due to limb flail and drogue chute opening shock for body weights below 140 pounds. ACES-II ejection attempts above 400 KEAS with body weights in excess of 211 pounds increase the risk of injury. Commanders may consider weight waivers and/or impose airspeed restrictions in the incentive or orientation flight profiles. Commanders waiving weight specifications must ensure the individual selected for incentive or orientation flight is briefed on the increase of injury risk prior to flight. Buttock-to-knee waivers to exceed maximum length are not authorized. The examining flight surgeon and MAJCOM/SG do not have waiver authority for indoctrination and incentive flights. (T-1)

6.24.5.2. Incentive and Orientation Flights in Non-Ejection Seat Aircraft.

6.24.5.2.1. Incentive and orientation flight candidates scheduled to fly in non-ejection seat aircraft will sign a locally generated health statement which asks the candidate: (1) Do you have any medical problems? (2) Are you on a DLC? (3) Do

you take any medications? (4) Do you feel you need to see a flight surgeon? Those individuals making any positive responses (YES) on the health statement will be referred by the flying unit to the flight surgeon for review, appropriate medical examination if deemed necessary and medical recommendation for incentive and orientation flying. (T-1)

6.24.5.2.2. Candidates must be able to safely egress the aircraft in an emergency without endangering life or limb.

6.24.5.2.3. All civilians selected for incentive or orientation flights will complete a locally generated health statement. These health statements must address any history of or current medical problems, medications individual is currently taking, and any physical limitations. All health statements on civilians will be referred by the flying unit to the flight surgeon for review, referral for appropriate medical examination to their health care provider if deemed necessary, and medical recommendation for incentive and orientation flying. (T-1)

6.24.5.2.4. Passengers scheduled to fly onboard Air Force aircraft will not routinely be referred to the flight surgeon office.

6.24.5.2.5. Communicate medical clearance, recommendations and/or restrictions to the flying unit on AF Form 1042 or DoD equivalent. Medical clearances for incentive and orientation flights are valid for no longer than 14 days with the exception of AMP 101 and AMP 202 candidates. See the AMP 101 website for further information. **Note:** ARC clearances will be valid for no longer than 40 days.

6.24.6. **Instructors and students participating in USAFA Airmanship programs.** The medical standards for these duties are the same as **Section 6G/6J** (except as noted below):

6.24.6.1. Flying Class III standards apply to Dean of Faculty (DF) parachute courses. FCII standards apply to all DF RPA programs. Flying Class II standards apply to all soaring/powered flight courses. The following exceptions apply:

6.24.6.1.1. Refractive error, no standards.

6.24.6.1.2. Applicants for programs in **6.24.6.1** may be cleared by a flight surgeon to fly if uncorrected visual acuity is not less than 20/25 in one eye and 20/20 in the other; while the applicant awaits delivery of corrective spectacles.

6.24.6.1.3. Color Vision, no Standard.

6.24.6.1.4. Depth perception:

6.24.6.1.4.1. No standard for DF flight, parachute, RPA, and student soaring programs provided the soaring instructor pilot has normal depth perception.

6.24.6.1.4.2. Participants with abnormal depth perception are disqualified from solo flight.

6.24.6.2. For USAFA flying and parachute programs, FAA 3rd class medical certificates are an acceptable standard of medical examination for civilian flight and parachute jump instructors, and USAFA Flying Team cadets. These participants will have their medical qualification reviewed by the USAFA/SGP, (or their appointed delegate) annually. A

USAFA Form 1042, will be generated prior to performing flying operations in USAFA owned aircraft.

6.24.6.3. Clearance to perform DF flight, student parachute, cadet jumpmaster, student soaring, cadet soaring instructor pilot, RPA, and powered flight programs are performed prior to flight and is contingent upon the cadet meeting the following requirements:

6.24.6.3.1. Compliance with **6.24.6.1** accomplished by review of all available medical documentation and appropriate physical examination to ensure standards are met.

6.24.6.3.2. Cadet Optometry Clinic performs a targeted optometry exam, if necessary, to determine at a minimum; refractive error, color vision, depth perception, and presence of any other potentially disqualifying ocular pathology.

6.24.6.3.3. Cadets receive risk communication in freshman year regarding airsickness, self medication, crew rest, not flying with a cold, alcohol and flying, and personal responsibility for seeing, or notifying, a flight surgeon for medical problems.

6.24.6.3.4. Cadets receive physiology training prior to flight or at least prior to solo flight.

6.24.6.3.5. Cadet/Flight Medicine Clinic flight surgeons issue a medical clearance for DF flight, soaring, Flying Team, RPA and parachute programs. The USAFA clearance will contain risk communication statements that reinforce the issues in **6.24.6.3.3** Participants initial these risk communication statements on the clearance document acknowledging their understanding. Cadets performing pilot-in-command or jump instructor/jumpmasters duties must have their medical clearance reviewed annually. (T-2)

6.24.6.3.6. Grounding management of all cadet participants will convey temporary disqualification and clearances following illness or injury to the local HARM. (T-2) For grounding management purposes, civilians will comply with all FAA regulations and guidance.

6.24.6.3.7. The USAFA airmanship program medical clearance expires upon graduation. While attending USAFA, the ability to continue performing USAFA Airmanship Program flying duties is continually evaluated and potentially altered based on routine medical encounters and the required commissioning/Flying Class I physical examination performed prior to graduation.

6.24.6.3.8. USAFA flying clearance (for DF, parachute, soar, RPA, or flight programs) does not imply meeting any other Air Force Initial Flying Class or special duty requirements such as I/IA/II/III, MOD, or GBC standards.

6.24.6.3.8.1. HQ AETC/SG certified Flying Class I physical examination must be completed prior to entering SUPT after graduation from USAFA.

6.24.7. **Interservice Transfers.**

6.24.7.1. Pilots of fighter, rotary wing, fixed wing (non-fighter) aircraft transferring from sister service to an equivalent weapon system in the Air Force are considered trained assets. Air Force FCII standards apply. Complete all requirements for pilot's age IAW

PHA and ASIMS guidelines. This FCII physical will be entered into PEPP for baseline comparison and into AIMWTS if flying waiver required. Pilots of fighter, rotary wing, and fixed wing (non-fighter) transferring to AF from a different type of weapon system are not considered trained assets. Flying Class I standards apply. These pilots would require initial FCI physical and successful completion of MFS. This FCI physical will be entered into PEPP and into AIMWTS if flying waiver required.

Chapter 7

MEDICAL EXAMINATIONS FOR SEPARATION AND RETIREMENT

7.1. Policy. Do not delay separation or retirement past scheduled date of separation or retirement to complete a medical examination unless medical hold is approved (see AFI 41-210 for further guidance on medical hold authority and related topics).

7.2. Purpose. To identify medical conditions requiring attention and to document current medical status to determine continued fitness for duty.

7.3. Presumption of Fitness. If performance of duty in the 12 months before scheduled retirement is satisfactory, the member is presumed to be physically fit for continued AD or retirement. (See AFI 41-210 for presumption of fitness prior to retirement). Reservists who have not been participating (in a no-pay/no-points status) solely due to administrative restrictions on participation IAW AFI 36-2254 Vol 1, *Reserve Personnel Participation* or due to noncompliance with requirements are not considered to overcome the presumption of fitness.

7.4. Law Governing Disability Evaluation.

7.4.1. Title 10, United States Code, Chapter 61 provides for disability retirement and separation.

7.4.2. Title 38, United States Code administered by the Department of Veterans Affairs governs disability compensation for ratable service-connected defects that have not precluded active service.

7.4.3. Title 10, United States Code Sec 1145 directs conduct of separation examinations on specific individuals leaving the USAF.

7.5. Mandatory Examinations.

7.5.1. All AD personnel will complete, as a minimum, a DD Form 2697 (see paragraph **1.5**) for separation or retirement. This will be reviewed and signed by a credentialed provider using local protocol. This will be initiated not earlier than 180 days of scheduled separation, retirement or beginning of terminal leave, and not later than 30 days prior to these events. If the service member requires a medical examination per **7.5.2**, the DD Form 2697 can be completed at that visit. (T-0)

7.5.1.1. The DD Form 2697 is only required for AFRC and ANG members leaving an AD tour of 31 days or more and is not required for retirement purposes if the PHA is current.

7.5.2. A medical examination by a credentialed provider as outlined in **7.5.3** is mandatory when:

7.5.2.1. Member has not had a PHA within one year.

7.5.2.2. If transferring to ARC, an AF Form 422**,** will be used to document the member's retention qualification. Members who are current on their PHA (within the 12 months preceding the actual date of retirement or separation) will complete a DD Form 2697 within 180 days of transfer, from which the need for further evaluation will be

determined. Potentially disqualifying conditions must be appropriately addressed prior to any Palace Chase/Front action. (T-1)

7.5.2.3. Medical authority requires an examination to be done for either clinical or administrative reasons.

7.5.2.4. Separation is involuntary, or is voluntary in lieu of trial by court martial, or retirement in lieu of involuntary administrative separation. **Exception:** Member is separated or retired in absentia.

7.5.2.4.1. If the member has had an initial enlistment/commissioning examination within the preceding 12 months, DD Form 2697 will be the only requirement.

7.5.2.5. Members having had a PHA within one year of AFPC approved retirement date (no DD Form 2808). The DD Form 2697 will be accomplished not earlier than 180 days prior to projected separation or retirement and not later than 30 days prior to projected separation or retirement. (T-0) Exceptions to meet mission requirements or short-notice separation/retirement will be handled on a case-by-case basis and must include coordination with the local VA transition officials if the member is expected to file a disability claim with the VA. (T-2)

7.5.2.6. The member is tentatively approved by HQ AFPC for early separation from AD and assignment into an ARC under PALACE CHASE or PALACE FRONT, and the member's most recent medical examination (PHA) was completed more than 12 months ago at the time of application. **Note:** Members with a disqualifying medical condition who desire to transfer to the ARC must undergo evaluation for Assignment Limitation Code or an MEB while on AD. (T-1)

7.5.2.7. The member's medical record has been lost. Accomplish PHA, DD Form 2807-1 along with the DD Form 2697. Provider examination must address significant medical history and determine if qualification for continued service is questionable. (T-1)

7.5.2.8. The member is a RPW (Mil-PDS assignment limitation code 5, or 7). The evaluation will include an I/RILO unless waived by HQ AFPC/DPANM. Forward a copy of the examination to the addresses in **6.4.7.4** (T-1)

7.5.2.9. Members of the reserve component separated from AD to which they were called or ordered in support of a contingency and for whom the period of AD exceeded 30 days. This includes ARC members called/ordered to initial AD for training, AD, or federal service during times of contingency, conflict, or war.

7.5.2.10. Members separated from AD who pursuant to voluntary agreement of the member to remain on AD for less than one year, unless **7.5.2.4.1** applies.

7.5.2.11. Members involuntarily retained on AD in support of a contingency unless they have a current (within 12 months preceding the actual date of separation) PHA.

7.5.2.12. Members who are being recommended for administrative separation IAW AFI 36-3208 under a characterization other than honorable and who have been deployed overseas in support of a contingency operation within 24 months prior to initiation of discharge and were diagnosed by a physician, clinical psychologist, or psychiatrist as experiencing Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI), or

reasonably alleges the influence of PTSD or TBI, based on deployed service to a contingency operation during the previous 24 months.

7.5.2.13. Review of DD Form 2697 determines a medical evaluation is required.

7.5.3. **Medical examination**. Members who require a separation examination IAW **7.5.2** will complete, as a minimum, a medical assessment as described below. (T-1) This assessment will be accomplished not earlier than 180 days of scheduled separation, retirement or beginning of terminal leave, and not later than 30 days prior to these events. (See paragraph **7.5.1**) (T-0)

7.5.3.1. The assessment must include:

7.5.3.1.1. A completed DD Form 2697 (see paragraph **1.5**). (T-1)

7.5.3.1.2. Clear documentation of any significant medical history and/or new signs or symptoms of medical problems since the member's last medical assessment/medical examination. (T-1) See the last two sentences in Section II, DD Form 2697 for additional guidance.

7.5.3.1.3. An examination by a privileged health care provider. When appropriate/required, examinations will be done and results documented in section II, item 20 of DD Form 2697. (T-1) The examination and studies will be those determined by the provider to be necessary to determine the examinee's continued qualification for worldwide service, evaluate significant items of medical history, or evaluate new signs and/or symptoms of injury or illness.

7.5.3.1.4. All personnel 35 years of age and older who are separating or retiring from the Air Force will complete screening for Hepatitis C per USPSTF recommendations. (T-1)

7.5.3.2. File the completed DD Form 2697 in the medical record. If the medical record is not available, forward sealed DD Form 2697 to the Separation and Retirements Section of the member's servicing MPF. File all consultation reports with the DD Form 2697.

7.5.3.3. Forward copies of medical examinations/medical assessments accomplished on ANG full-time AGR Title 32, EAD Title 10 members to HQ Air Reserve Personnel Center (ARPC). ARPC/DSFRA for retention as required by Title 10, United States Code, Chapter 8502.

7.5.3.4. Forward a copy of DD Form 2697 (ensure HIPAA compliance with signed authorization from the member) to the In-Service recruiter for all members entering an ARC through the PALACE CHASE/FRONT Programs.

7.5.4. HIV testing for separation or retirement is required only when deemed appropriate by the primary care manager (see AFI 48-135).

7.5.5. Termination Occupational Examinations. If a termination occupational examination is required, the separation or retirement examination/assessment can be accomplished during this examination.

7.6. General Officers. Examinations for retirement must be conducted IAW AFI 36-3203, *Service Retirements*, Chapter 5.5.

Chapter 8

MEDICAL CLEARANCE FOR JOINT OPERATIONS OR EXCHANGE TOURS

8.1. Applicability. Air Force personnel must meet Air Force standards while in joint assignments, or inter-Service exchange tours. The host nation is the nation where TDY flying duties take place, or the nation with primary aeromedical responsibility. The parent nation is the nation of whose armed services the individual is a member.

8.1.1. Waiver authority is the Air Component Surgeon (i.e., ACC/SG for CENTCOM and SOUTHCOM; AFSOC/SG for SOCOM and USSOCOM; STRATCOM/SG for STRATCOM and AMC/SG for TRANSCOM), or the MAJCOM/SG responsible for administrative management of the member.

8.1.2. In cases where no qualified Air Force flight surgeon is assigned to the Air Component Surgeon's office, or the waiver authority is uncertain, waiver authority is AFMSA/SG3P.

8.1.3. Medical examinations performed by other services are acceptable, but must be reviewed and approved by the appropriate Air Force waiver authority.

8.1.4. Waivers for flying or other special duty positions granted by another service or nation may not necessarily be continued upon return to Air Force command and control.

8.2. Joint Training.

8.2.1. The Air Force accepts waivers granted by the parent service prior to the start of training unless there is a serious safety concern or information is available which was not considered by the waiver authority.

8.2.2. After students in-process at the host base, the administrative requirements and medical management policies of the host base apply.

8.2.3. Students must meet the physical standards of the parent service.

8.2.4. If individuals develop medical problems while in training, the training must not be continued unless both host and parent services concur.

8.2.5. In cases of irreconcilable conflict, host service decision takes precedence (consult with MAJCOM/SG for further guidance).

Chapter 9

NATO AND OTHER FOREIGN MILITARY PERSONNEL

9.1. Implementation. This chapter implements STANAG 3526, Interchangeability of NATO Aircrew Medical Categories.

9.2. Evidence of Clearance. Definitions: The host nation is the nation where TDY flying duties take place, or the nation with primary aeromedical responsibility. The parent nation is the nation of whose armed services the individual is a member.

9.2.1. Local (Host) MTF flight surgeons prepare AF Form 1042 or DoD equivalent based on the standards of medical fitness for flying duties issued by the parent country.

9.2.1.1. Aircrew on TDY for greater than 30 days are to have a copy of their latest complete flight physical with pertinent information and documentation helpful for post-accident identification purposes (fingerprints, footprints, DNA profile, etc.).

9.2.2. If the aircrew member does not have documentary evidence of a parent nation physical within 12 months, the flight surgeon will complete an aircrew physical. (T-1)

9.2.2.1. Pre-existing conditions, waived by the parent NATO nation will be accepted by the USAF as long as health or safety is not compromised. Pre-existing conditions waived by non-NATO parent nations will be accepted IAW the agreement between USAF and parent nation.

9.2.3. In the case of progression of a pre-existing condition, development or discovery of a new medical condition, the host nation medical standards apply and remain in effect for that individual aircrew member whenever in that host nation (see **9.2.5**).

9.2.4. Periodic examinations for flying are conducted according to the host nation's regulations. A copy of the examination is sent to the aeromedical authority of the parent nation.

9.2.5. Groundings exceeding 30 days and permanent medical disqualification must be discussed with AFMSA/SG3P and the appropriate parent nation liaison. (T-1)

9.3. Medical Qualification of NATO Aircrew Members:

9.3.1. NATO Aircrew will have the same medical benefits and requirements as USAF aircrew (See AFI 41-210). **Note:** Members must have documentation in the medical record that a DNA sample has been obtained and on record. (T-1)

9.3.2. Waivers for flying/SOD duty positions granted by another nation may not necessarily be continued upon return to the USAF.

9.4. Medical Qualification for Security Cooperation Education and Training Program (SCETP) Flying (Non-NATO Students):

9.4.1. Flying student candidates will complete a medical and dental examination using DD Form 2807-1 and DD Form 2808, within three months prior to departure from parent country IAW AFI 16-105, *Joint Security Cooperation Education and Training.*

9.4.2. All medical qualification documentation will be forwarded through SCETP to the training MTF SGP, where case will be reviewed and any missing items will be added and forwarded to AETC NLT 30 days before training or Defense Language Institute (DLI) start date. AETC/SGP will determine if the flying student candidate possesses adequate physical examination documentation and is qualified under **Chapter 6, Section 6G** and the Medical Standards Directory. AETC/SGP will certify student as qualified with or without waiver on the DD 2808 (attach documents to PEPP, (AIMWTS is not required on these students)) prior to issuing Invitational Travel Order (ITO) IAW JSCET.

9.4.3. ny student who fails to meet medical standards will be managed on an individual basis by HQ AETC/SG and HQ AETC/IA, who will in turn, coordinate with AF/SG (AFMSA/SG3P), SAF/IA as appropriate.

9.5. Non-NATO Aircrew. For non-NATO aircrew, specific memorandums of agreement between the United States and parent nation take precedence over this chapter if in conflict.

Chapter 10

EXAMINATION AND CERTIFICATION OF ARC MEMBERS NOT ON EAD

10.1. Purpose. Establishes procedures for accomplishing, reviewing, certifying, and administratively processing medical examinations for ARC members not on EAD who are assigned to the Ready Reserve and Standby Reserve. IAW AFI 36-2254 Vol I, any USAFR member profiled with a duty limiting condition code 37 may not perform military duty for pay or points, unless issued a participation waiver by the AFRC/SGP or delegated authority.

10.2. Applicability.

10.2.1. ARC Unit and individual members of the ANG and Air Force Reserve, IMA.

10.2.2. ARC Members of the Ready Reserve:

10.2.2.1. Air National Guard. Administered by ANG/SGP.

10.2.2.2. Air Force Reserve Unit/IMA/Participating Individual Ready Reserve (PIRR) Members. Administered by HQ AFRC/SGP, Aerospace Medicine Division)

10.2.3. Nonparticipating Members of the Ready, Standby, and Retired Reserve. These members are ordered to EAD only in time of war or national emergency declared by the Congress.

10.3. Medical Standards Policy. Each ARC individual must be medically qualified for deployment and continued military service according to **Chapter 5**, the Medical Standards Directory and **Chapter 11**.

10.4. Responsibilities.

10.4.1. Commander or Supervisor. Each ARC commander or active force supervisor ensures an ARC member is medically qualified for WWD. Each commander and supervisor notifies the servicing medical facility when he/she becomes aware of any changes in an ARC member's medical status.

10.4.2. ARC Member. Each ARC member is responsible for promptly (within 72 hrs) reporting an illness, injury, disease, operative procedure or hospitalization not previously reported to his or her commander or supervisor, and supporting medical facility personnel IAW AFI 36-2910. Any concealment or claim of disability made with the intent to defraud the government results in possible legal action and possible discharge from the ARC.

10.4.3. ARC Physicians. Responsible for determining ARC member's medical qualifications for continued WWD IAW this instruction and appropriate ARC supplemental guidance.

10.4.4. Air Force medical service personnel record any illness, injury or disease incurred or aggravated by ARC members during any training period on appropriate medical forms to include initiation of a line of duty determination, since the illness, injury, or disease may be used as the basis for government claims leading to potential benefits and entitlements IAW AFI 36-2910.

10.5. General Responsibilities/ARC Medical Units.

10.5.1. Establish health and dental records for each ARC member.

10.5.2. Forward original IMA medical examinations to the AD MTF where the individual's medical records are maintained. If a disqualifying condition is identified, an appropriate AF Form 469 must be generated and forwarded to the Physical Evaluation Board Liaison Officer **(**PEBLO) at the AD MTF. (T-1) Initial RILO/MEB packages shall undergo standard processing through the MTF and Informal Physical Evaluation Board (IPEB). (T-1) HQ AFRC/SGP retains authority to assign Assignment Limitation Code C (ALC-C) codes for IMAs returned to duty IAW AFI 41-210.

10.5.3. Medical examinations accomplished on unit assigned and IMA members of the AFR are subject to review by AFRC/SGP to verify their medical qualification for continued military duty. AFRC/SGP is the final authority in determining medical qualifications for all reserve personnel.

10.5.4. All ANG medical examinations are maintained by the servicing medical unit and are subject to review by NGB/SGP to verify qualification for participation. NGB/SGPA is the final authority in determining ANG member qualification for WWD.

10.5.5. For ARC members with questionable medical conditions or found medically disqualified send complete medical case files as noted. For Air Force Reservists, send requested medical documents to AFRC/SGP at **afrc.sgp@us.af.mil** or through the Electronic Case Tracking (ECT) system for review of questionable or disqualifying medical conditions. For Air National Guard members, send medical case files to: NGB/SGPA, 3500 Fetchet Avenue, Andrews AFB, MD 20762-5157; for Air Force Reserve members (unit assigned and IMA), send to: HQ AFRC/SGPA, 135 Page Road, Robins AFB, GA 31098-1601.

10.6. Inactive/Retired Reserve. Applicants currently assigned to the inactive or Retired Reserve or retired from active military service for less than 5 years may request entry to active reserve status.

10.6.1. The appropriate ARC/SG must review and certify all applicants identified with **Chapter 5** and Medical Standards Directory disqualifying medical conditions; history of MEB evaluation, fitness for duty evaluation, or ALC-C status; applying for a different aircrew AFSC from their previous aircrew assignment, require a medical waiver for flying, or retired from a sister service.

10.6.2. The Chief, Aerospace Medicine of the gaining/supporting AFRC medical unit or AD MTF and ANG SAS may certify, but not waiver for entry into active reserve status, all applicants not identified in paragraph **10.6.1** above using **Chapter 5** and the Medical Standards Directory.

10.6.2.1. Individuals diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) must be carefully evaluated for suitability for continued service. If treatment with medication is required, a WWD evaluation and waiver request to ANG/SG is required.

10.6.3. The following documentation is required for all applicants:

10.6.3.1. Current DD Form 2807-1.

10.6.3.2. Current Reserve Web HA with supporting documentation for positive responses (AFRC only).

10.6.3.3. PHA with associated paperwork less than 12 months old (non aircrew assignments).

10.6.3.4. Flying PHA with associated paperwork less than 12 months old (aircrew assignment same as previous aircrew AFSC).

10.6.4. Applicants applying for a new aircrew position, rather than the one previously held will require an initial flying exam. Applicants whose Reserve Component Health Risk Assessment (RCHRA) or PHA is greater than 12 months old will require a current enlistment or flying exam as appropriate.

10.7. Reenlistment. Ensure members who want to reenlist in the ANG have a current PHA. Ensure members, who want to reenlist in AFRC, complete a current RCHRA unless a PHA or RCHRA less than 12 months is on file.

10.8. Reinforcement Designees Pay or Points. Annually, prepare the appropriate form for Reinforcement Designees not participating for pay or points. Members who feel their medical qualification is in question attach medical documentation to the appropriate form and return the entire package to HQ ARPC/DSFS, Denver, CO 80280-5000.

10.9. General Officers. ANG medical units will maintain the annual PHA accomplished on general officers and ANG wing commanders in the medical records. Reserve medical units will forward to HQ AFRC/SGPS, a copy of all physical examinations accomplished on reserve wing commanders.

10.10. AGR Tours. The AGR program requires individual applicants to contact the appropriate ARC medical unit, or AD MTF, to request the appropriate medical evaluation. The following guidance along with AFI 36-2132V2, *Active Guard/Reserve (AGR) Program*, and ANGI 36-101, *Air National Guard Active Guard Reserve (AGR) Program*, will be used to manage these requests.

10.10.1. General. Members selected for initial AGR positions must meet the medical standards as outlined in this AFI prior to assignment. Applicants who have started an AGR tour and are found to have medical conditions(s) which makes their medical qualifications for continued military duty questionable will be processed through the Air Force DES IAW AFI 36-3212.

10.10.2. Physical Exam Requirements.

10.10.2.1. Applicants with a concurrent AGR assignment must have a current PHA on file.

10.10.2.2. Applicants with no service affiliation (i.e. Individual Ready Reserve (IRR), AD, reserve, guard, etc.) require an accession physical exam, which would be valid for 24 months prior to AGR assignment. See medical standards in **Chapter 4** and **Chapter 6**, Medical Standards, **Section 6G** (aircrew applicants only).

10.10.2.3. Active military (AD, ARC) applicants for non-aircrew assignments may use PHA with associated documentation less than 12 months old. Members must also be current in all IMR requirements. AF Form 422, must be dated within 60 days prior to tour start date. Medical standards in **Chapter 5** and Medical Standards Directory apply. Prior service (IRR, etc.) applicants for non-aircrew assignments within 180 days of separation may use the same standards as AD. Applicants whose date of separation is

greater than 180 days will require an accession examination and medical standards in **Chapter 4** apply.

10.10.2.4. For aircrew assignments into the applicant's current aircrew AFSC, flying PHA with associated paperwork less than 12 months old may be used.

10.10.2.4.1. Applicants for new aircrew assignments require an initial flying examination.

10.10.3. ertification/Waiver Authority.

10.10.3.1. AFRC/SGP is the certification and waiver authority for all AFRC AGR applicants.. For ANG, the SAS, having completed specialized training, is authorized certification authority for Title 32 AGR applicants. Medical Standards in Chapter 5, Medical Standards Directory and Chapter 6, Section 6G apply.

10.10.3.1.1. The Chief, Aerospace Medicine/SAS for the ANG will certify the appropriate medical document with a certification stamp. Delegation of this certification authority is extended only to those Reserve Medical Units responsible for providing physical exam support.

10.10.3.2. The appropriate ARC/SG is the reviewing, certification and waiver authority (see **Attachment 2**) for those applicants with disqualifying medical conditions in **Chapters 4, 5,** Medical Standards Directory **and Chapter 6**, **Section 6G**, except initial entry into IFCI/IA/II, unless otherwise directed by other guidance within this instruction. Also, the appropriate ARC/SG is the certification authority for all MAJCOM or higher-level AGR positions (ANG Title 10 EAD) and those positions with no gaining ARC medical units.

10.11. Involuntary EAD. ARC members involuntarily ordered to AD will not delay such action because of an expired PHA. See AFI 44-170 for details.

10.11.1. An ARC member ordered to EAD due to mobilization is medically processed IAW the mobilization order. The ARC member's medical status must be established within 30 days of mobilization.

10.11.2. Within 30 days of mobilization, the health records of the ARC member will be reviewed for disqualifying defects according to **Chapter 5** and Medical Standards Directory and to determine if the member's PHA is current. Members found medically disqualified or questionably qualified for WWD are evaluated IAW AFI 41-210, unless otherwise directed by the mobilization order.

10.12. Annual Training (AT) or AD for Training or Inactive Duty for Training (IDT). Commanders ensure members reporting for duty are medically qualified. Members with medical conditions, which render questionable their medical qualifications for continued WWD, are evaluated for fitness for duty.

10.13. Inactive Duty for Training.

10.13.1. ARC members who are ill, sustain an injury, or do not consider themselves medically qualified for military duty can request excusal from training.

10.13.2. If a member reports for duty and does not consider him or herself medically qualified for continued military service based on a diagnosis from the PCM, the ARC

commander or AD supervisor will schedule the member for a medical evaluation during the IDT period. (T-1) If the member is not qualified for WWD, a medical evaluation is sent to AFRC/SGP, or NGB/SGPA as appropriate. (T-2) The member is excused from training pending a review of the case. **Note**: ARC members will be given a DLC (AF Form 469) and follow the guidance found in AFI 10-203.

10.13.3. When a commander, supervisor, or medical personnel determines an ARC member's medical condition is potentially unfit, he or she is evaluated by the servicing medical squadron and is excused from all military duties pending further medical disposition.

10.14. Medical Examination.

10.14.1. General Information:

10.14.1.1. Medical personnel perform medical examinations according to **Chapter 1** and physical examination techniques.

10.14.1.2. All personnel undergo an annual dental examination according to the PHA grid at the time of the PHA. Bitewing radiographs are accomplished at the discretion of the examining dental officer for diagnostic assistance.

10.14.1.3. The PHA is an annual requirement for members of the ARC, IAW AFI 44-170, Preventive Health Assessment.

10.14.1.4. ANG MPF and commander are notified by the ANG Medical Group when a member cannot continue the United Training Activity (UTA) because of a medical condition. AF Form 469 is used for notification, as appropriate.

10.14.2. Dental Class III.

10.14.2.1. AFRC members placed in dental class III are not qualified for military duty other than at home station until returned to Dental Class 1 or 2. Manage AFRC members IAW paragraph **10.16** of this instruction unless the dental officer has determined the member may continue reserve participation in restricted status. ANG members placed in Dental Readiness Class III are not IMR ready and are non-deployable. Members are placed on an AF Form 469 code 31 for mobility restrictions. Members in Dental Readiness Class III lasting for more than one year will be processed administratively IAW AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members* unless the member has a dental defect defined in **Section 5B** of this instruction. Members with a dental defect defined in **Section 5B** of this instruction and the Medical Standards Directory will be processed for Initial RILO/MEB/WWD. More Guidance in AFI 47-101.

10.14.2.2. The examining military dental officer has the authority to allow AFRC in dental class III to continue Reserve participation at home duty station only while undergoing corrective dental treatment. The dental officer will determine the length of time (not to exceed 1 year) given to a member to complete dental treatment or improve to at least dental class II.

10.14.2.2.1. Aircrew members in dental class III will be placed on DNIF status unless the examining dental officer determines the AFRC member may continue reserve participation and the flight surgeon determines flying safety will not be compromised. (T-1) Aircrew in this status will be limited to local sorties only. (T-1)

10.15. Scheduling PHA. Schedule a PHA in accordance with current ARC directives ASIMS/PHA Guide.

10.16. Medical Evaluations to Determine Fitness for Duty.

10.16.1. Reasons to accomplish medical evaluations in determination of medical and dental qualification for military duty:

10.16.1.1. Disqualifying or questionable medical conditions discovered during the annual assessment.

10.16.1.2. Notification or awareness of a change in the member's medical status.

10.16.1.3. ARC member believes he or she is medically disqualified for military duty.

10.16.2. Reservists and ANG members with medical or dental conditions which are questionable or disqualifying for military duty must have an evaluation accomplished and forwarded to the appropriate ARC/SG for review and appropriate action. (T-1) Members will be given a minimum of 60 days from the date of notification to provide civilian medical or dental information to the medical squadron prior to case submission to the ARC/SG. (T-1) The local military provider may give the member more time as considered necessary to provide the requested information. However, under no circumstances will the time exceed 1 year. (T-1)

10.16.3. Notification. The commander or supervisor notifies the ARC member, in writing, to report for the medical evaluation.

10.16.4. Accompanying Documents. The following documents are included in the reports forwarded to the appropriate component surgeon (see **paragraph 10.5**) for review. Note: For AFRC, submit documents through the ECT system.

10.16.4.1. For unit assigned or IMA reserve members:

10.16.4.1.1. Civilian medical and dental documentation.

10.16.4.1.2. Current letter from member's private physician or dentist.

10.16.4.1.3. AF Form 469 properly formatted.

10.16.4.1.4. SF 502, Medical Record - Narrative Summary (Clinical Resume), must provide a clear picture of the member's current medical health as well as the circumstances leading to it. (T-1)

10.16.4.1.5. Medical Evaluation (ME) for Military Duty Fact Sheet.

10.16.4.1.6. PEB Election.

10.16.4.1.7. PEB Fact Sheet.

10.16.4.1.8. AF Form 422.

10.16.4.1.9. Unit Commander Memorandum.

10.16.4.1.10. Member Utilization Questionnaire.

10.16.4.2. For ANG members:

10.16.4.2.1. Unit commander's endorsement.

10.16.4.2.2. SF 502, Narrative Summary must include:

10.16.4.2.2.1. Date and circumstance of occurrence.

10.16.4.2.2.2. Response to treatment.

10.16.4.2.2.3. Current clinical status.

10.16.4.2.2.4. Proposed treatment.

10.16.4.2.2.5. Current medications.

10.16.4.2.2.6. The extent to which the condition interferes with performance of military duty (see **Chapter 11**).

10.16.4.2.2.7. Prognosis.

10.16.4.2.3. Civilian medical documentation. Medical documentation from the member's civilian health care provider will be included in all waiver cases submitted on ARC members. (T-1) The provider will review this information and reference it in the SF 502, *Narrative Summary*. (T-1)

10.16.4.2.4. A written statement from the member's immediate commanding officer describing the impact of the member's medical condition on normal duties, ability to deploy or mobilize, and availability of a non-deployable (ALC-C) position.

10.16.5. Reports. A member who is unable to travel submits a report from his or her attending physician to their commander or supervisor who, in turn, submits the report to the servicing ARC medical squadron for review and determination of fitness for duty.

10.17. Failure to Complete Medical Requirements. ARC members who fail to complete medical/dental requirements are referred to their commanders in writing IAW AFMAN AFI 36-2254 Vol I and are processed IAW AFI 36-3209.

10.17.1. Refusal. A member of the ARC with a known medical or dental condition who refuses to comply with a request for medical information or evaluation is considered medically unfit for continued military duty and is referred to their immediate commander for processing IAW AFI 36-3209. Reservists or Guardsmen who fail to provide documents or appear for scheduled appointments are considered to be non-compliant and will be referred to their Commander in writing for administrative separation IAW AFI 36-3209.

Chapter 11

MOBILITY STANDARDS AND DEPLOYMENT CRITERIA

11.1. General Considerations. For the purposes of this instruction mobility status is an ongoing condition where the member is free from any chronic medical conditions or limitations other than temporary limitations (under 1 year) that would preclude an Air Force deployment or TDY for six months in field conditions. A fitness for deployment determination is an assessment of current medical condition. A deployment (as defined in this instruction) is defined as any temporary duty where Contingency, Exercise, and Deployment TDY orders were issued, and the TDY location is outside of the United States. ANG deployment is greater than 30 days regardless of location. Conditions, which may seriously compromise the near-term well being if an individual were to deploy, are disqualifying for mobility status or deployment duty. 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, a member must be able to perform duty in austere environment with no special food, billeting, medical or equipment support for up to 179 days. See DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees* for medical standards not consistent with deployment. Also review CoCOM reporting instructions for individuals tasked to deploy. **Note**: For DoD civilian employees, DoDD1400.31, *DoD Civilian Work Force Contingency and Emergency Planning and Execution*, and DoDI 1400.32, *DoD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures*, See DoDI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees* and AFI 36-507, *Mobilization of the Civilian Workforce* apply. Civilian Contractors shall follow DoDI 3020.41, *Operational Contract Support (OCS)*. (T-0)

11.1.1. Individuals returned to duty as "fit" by PEB may not meet deployment standards. Such individuals, if they are retained, will have assignment limitation codes limiting or restricting them from deployment duties or be placed on Limited Assignment Status (LAS). They may be assigned or deployed with appropriate coordination per AFI 41-210.

11.1.2. The deployment standards in DoDI 6490.07 are the minimum necessary to maintain mobility status (see Kx for additional USAF Guidance). (T-1) Any individual who cannot maintain mobility status for a chronic or recurrent medical condition must meet an initial RILO or MEB evaluated IAW 41-210. **Note**: Pregnancy does not require an MEB and is handled as a code 81 mobility restriction annotated on an AF Form 469. Any mobility (or TDY) restrictions following completion of pregnancy are detailed in AFI 36-2110, *Assignments*.

11.1.3. Any individual having a deployment or assignment cancelled due to medical reasons must be referred to the DAWG within 10 calendar days for appropriate action IAW AFI 10-203.

11.1.4. ARC members must have deployment criteria addressed in the Narrative Summary submitted in the WWD Medical Evaluation package for the purpose of enabling the ARC/SG to make a valid deployability determination.

11.2. Non-mobility status personnel (ALC-C1, 2, 3 or LAS or ANG members with a condition waived for WWD) who have existing medical conditions may deploy if all of the following conditions are met and approved by the gaining COCOM.

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

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

11.2.3. Any required ongoing health care or medications must be available in-theater within the military health system. All special requirements (e.g. special handling, and storage) must receive prior approval by gaining COCOM.

11.2.4. There is no need, or anticipation of a need, for duty limitations that preclude performance of duty or accommodation imposed by the medical condition (the nature of the accommodation must be considered).

11.2.5. There is no need for routine evacuation out of theater for continuing diagnostics or other evaluations. (All such evaluations must be accomplished prior to deployment).

11.2.6. Coordination with deployed commanders (or delegated waiver authority) may be required based on current conditions, host nation requirements or changing mission requirements.

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Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Medical Standards Directory

Official Air Force Aerospace Medicine Approved Medications Quick Reference List
https://kx.afms.mil/kxweb/dotmil/file/web/ctb_128486.pdf

Physical Examination Standards

https://kx.afms.mil/kxweb/dotmil/kjPage.do?cid=ctb_155907&functionalArea=Aerospace Medicine

Adopted Forms

DD Form 771, *Eyewear Prescription*

DD Form 2351, *DoD Medical Examination Review Board (DODMERB) Report of Medical Examination*

DD Form 2492, *Report of Medical History*

DD Form 2697, *Report of Medical Assessment*

DD Form 2766, *Adult Preventive and Chronic Care Flowsheet*

DD Form 2807-1, *Report of Medical History*

DD Form 2808, *Report of Medical Examination*

SF 507, *Clinical Record-Continuation Sheet*

SF 600, *Medical Record – Chronological Record of Medical Care*

AF Form 469, *Duty Limiting Condition Report*

AF Form 422, *Notification of Air Force Member's Qualification Status*

AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log*

AF Form 1042, *Medical Recommendations for Flying or Special Operational Duty*

AF Form 1418, *Recommendation for Flying or Special Operation Duty – Dental*

AF IMT 847, *Recommendation for Change of Publication*

Abbreviations and Acronyms **ACS**—
Aeromedical Consultation Service

ACSCL—Aircrew Soft Contact Lens

AD—Active Duty

ADHD—Attention Deficit Hyperactivity Disorder

AFECD—Air Force Enlisted Classification Directory

AETC—Air Education and Training Command **AFI**—
Air Force Instruction

AFMOA—Air Force Medical Operations Agency

AFMSA—Air Force Medical Support Agency

AFOCD—Air Force Officer Classification Directory

AFPC—Air Force Personnel Center

AFR—Air Force Reserve

AFRC—Air Force Reserve Command

AFRIMS—Air Force Records Information Management System

AFROTC—Air Force Reserve Officer's Training Corps **AFSC**—
Air Force Specialty Code

AF/SG—Headquarters United States Air Force Surgeon General

AGR—Active Guard Reserve

AIMWTS—Aeromedical Information Management Waiver Tracking System

ALC—C – Assignment Limitation Code C

AMP—Aerospace Medicine Primary

AMS—Aeromedical Summary **ANG**—
Air National Guard

ARC—Air Reserve Component (AFR and ANG)

ARC SURGEON—AFRC/SGP for unit assigned and IMA members of the Air Force Reserve; ANG/SGP for guardsmen

ARMA—Adaptability Rating for Military Aviation

ARPC—Air Reserve Personnel Center

ASA—Air Sovereignty Alert **ASC**—

Aviation Service Code

ASIMS—Aerospace Medicine Information Management System

BMC—Basic Mission Capable

BMTS—Basic Military Training School

CCT—Cone Contrast Test **CL**—

Contact Lenses

CMR—Combat Mission Ready

CRO—Combat Rescue Officer **DAWG**—

Deployment Availability Working Group **DF**—Dean

of Faculty

DLC—Duty Limiting Condition **DNIA**—

Duties Not to Include Alert **DNIC**—

Duties Not Including Controlling **DNIF**—

Duties Not Involving Flying **DoD**—

Department of Defense **DoDD**—

Department of Defense Directive **DoDI**—

Department of Defense Instruction

DODMERB—Department of Defense Medical Examination Review Board

DSM—Diagnostic and Statistical Manual

EAD—Extended Active Duty **ECT**—

Electronic Case Tracking **EPTS**—Existing

Prior to Service **FAA**—Federal Aviation

Administration **FC**—Flying Class

FDA—Food and Drug Administration

FFD—Fitness for Duty

FHME—Force Health Management Element

FS—Flight Surgeon

GBC—Ground Based Controller **G6PD**—
Glucose-6-phosphate dehydrogenase **HARM**—
Host Aviation Resource Management
HIPAA—Health Insurance Portability and Accountability Act
HIV—Human Immunodeficiency Virus **HPSP**—
Health Professions Scholarship Program **IDES**—
Integrated Disability Evaluation System **IDT**—
Inactive Duty for Training
IFC—Initial Flying Class **IGAB**—
Inspector General Advisory Board **IMA**—
Individual Mobilization Augmentee
IMR—Individual Medical Readiness
IRR—Individual Ready Reserve
JSCET—Joint Security Cooperation Education and Training
KEAS—Knots Equivalent Air Speed
KX—Knowledge Exchange **LEP**—
Laser Eye Protection **MAJCOM**—
Major Command **MDD**—Marine
Diving Duty **MEB**—Medical
Evaluation Board
MEPS—Military Entrance Processing Station
MFS—Medical Flight Screening **MPF**—
Military Personnel Flight **MOD**—Missile
Operations Duty **MRI**—Magnetic Resonance
Imaging **MTF**—Medical Treatment Facility
NATO—North Atlantic Treaty Organization
NOMI—Naval Operational Medicine Institute
NVG—Night Vision Goggle **OM**—
Occupational Medicine
OTC—Over the Counter
PCM—Primary Care Manager

PEB—Physical Evaluation Board

PEPP—Physical Examination and Processing Program

PHA—Preventive Health Assessment

PHI—Protected Health Information

PIM—Pre-trained Individual Manpower

PIP—Pseudoisochromatic Plates

PSR—Patient Status Report **RDS**—

Records Disposition Schedule

RHRP—Reserve Health Readiness Program

RILO—Review in Lieu of **ROTC**—

Reserve Officer Training Corps **RPA**—

Remotely Piloted Aircraft **RPW**—

Repatriated Prisoner of War **RTFS**—Return

to Flying Status

SAS—State Air Surgeon

SCETP—Security Cooperation Education and Training Program

SCL—Soft Contact Lenses

SERE—Survival, Evasion, Resistance, and Escape

SOD—Special Operational Duty **SRTS**—

Spectacle Request Transmission System

SUAS—O – Small Unmanned Aircraft Systems Operators

TDRL—Temporary Disability Retirement List **TDY**—

Temporary Duty

TFI—Total Force Initiative **UDS**—

Urine Drug Screen **UFT**—

Undergraduate Flying Training

UNT—Undergraduate Navigator Training **UPT**—

Undergraduate Pilot Training **URT**—Undergraduate

Remotely Piloted Aircraft Training **USAFA**—United

States Air Force Academy

USAFR—United States Air Force Reserve. Includes unit assigned reservists and Individual Mobilization Augmentees

USAFSAM/FECO—United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division, Ophthalmology Branch

USUHS—Uniformed Services University of Health Sciences

WEB HA—Web Health Assessment

WWD—Worldwide Duty

Attachment 2

CERTIFICATION AND WAIVER AUTHORITY

Table A2.1. Certification and Waiver Authority.

Attachment 2 Table A2.1. Certification & Waiver Authority		
Category	**Certification Authority**	**Waiver Authority**
Flying Class I, IA Includes AD, Reserves, ANG	AETC/SGPS	AETC/SGPS
Initial FCII		
On or entering AD	AETC/SGPS	AETC/SGPS
Reserves	AFRC/SG (AMP)	AETC/SGPS
ANG	ANG/SG (AMP)	AETC/SGPS
Test Pilot School Flying Class II	AFMC/SGPA	AFMC/SGPA
Continued Flying Class II		**MAJCOM/SG**
Flying Class III		
Initial (AD) Required by AFSC	AETC/SGPS	AETC/SGPS
Initial (Reserves)	AFRC/SG	AFRC/SG
Initial (ANG)	State Air Surgeon (ANG)	ANG/SG
Continued Flying (All)	Local Base Certification/Waiver Authority	MAJCOM/SG
Flight Test Engineers and Developmental Engineers	AFMC/SGPA	AFMC/SGPA
Special Operational Duty		
Initial AD	AETC/SGPS	AETC/SGPS
Initial Reserves	Appropriate ARC SG	AFRC/SG
Initial ANG	State Air surgeon (ANG)	State Air Surgeon (ANG)
Continued Special Operational Duty	Local Base Certification/Waiver Authority	MAJCOM/SG
Operational Support Duty		
AD	Local Base Certification/Waiver Authority	Local Base Certification/Waiver Authority Local
Reserves	Local Base Certification/Waiver Authority	Local Base Certification/Waiver Authority
ANG	State Air Surgeon (ANG)	State Air Surgeon (ANG)

Missile Operations Duty		
AD	AFGSC/SG	AFGSC/SG
Reserves	AFGSC/SG	AFGSC/SG
ANG	State Air Surgeon ANG	AFGSC/SG
USAFA Cadet Incentive Flight, cadet parachute, cadet jumpmaster, cadet soaring, and cadet soaring instructor pilot duties, and powered flight programs	USAFA/SGP	USAFA/SGP
Initial Commission		
Entering AD	MEPS	AETC/SG
Extended AD (Res/ANG to AD)	AETC/SGPS	AETC/SGPS
Entering Reserves	MEPS for non-prior service AFRC/SG for prior service	AFRC/SG
Entering ANG	MEPS for non-prior service AFRC/SG for prior service	ANG/SG
USAFA	USAFA/SG	USAFA/SG
Change In Commission Status without Break in Service		
AD	Local Base Certification/Waiver Authority	AFPC/DPANM
Reserve Program	AFRC/SG	AFRC/SG
ANG	State Air Surgeon (ANG)	ANG/SG
Officer Program Applicants		
USAFA	DODMERB	USAFA/SG/SGP
ROTC	DODMERB	AETC/SGPS
USUHS	DODMERB	Assistant Secretary of Defense Health Affairs (ASD HA)
HPSP	MEPS	AETC/SGPS
Special Officer Procurement	AETC/SGPS	AETC/SGPS
AF Initial Enlistment		
AD	MEPS	AETC/SGPS
Reserves	MEPS IRR (AFRC/SG)	AFRC/SG
ANG	MEPS	ANG/SG
Continued Military Service/WWD following MEB		
AD (MEB)	AFPC/DPANM	
Reserves		AFRC/SG

ANG		ANG/SG
Return to AD following break in service	MEPS	AETC/SGPS
Recall to AD ARC		AFPC/DPANM
PALACE CHASE or FRONT Reserves ANG	 AFRC/SG ANG Medical Group	 AFRC/SG ANG/SG
AGR Tours		
Base Level AGR tour (ANG Title 32)		
Reserves	AFRC/SG	ARC SG
ANG	State Air Surgeon (ANG)	ANG/SG
MAJCOM Level AGR Tour (ANG Title 10)		
Reserves	AFRC/SG	AFRC/SG
ANG	ANG/SG	ANG/SG
Static Line, Free Fall, HALO, Jump Master (Required for AFSC)		
Initial AFSC Entry	Local Base Certification/Waiver Authority	AETC/SGPS
Trained Asset: Upgrade and Additional Duty Training	Local Base Certification/Waiver Authority	MAJCOM/SG
Static Line, Free Fall, HALO, Jump Master (Not required for AFSC)		
AD	Local Base Certification/Waiver Authority	MAJCOM/SG
Reserves	AFRC/SG	AFRC/SGPS
ANG	State Air Surgeon (ANG)	ANG/SG
Ground Based Controllers (ATC, TAC-P, ALO, 1U0XX, etc)		
Initial AD	Local Base Certification/Waiver Authority	AETC/SGPS
Trained AD		MAJCOM/SG
Reserves Initial/Trained	AFRC/SG	AFRC/SG
ANG Initial/Trained	State Air Surgeon (ANG)	State Air Surgeon (ANG)

Note: ***AFMSA/SG3PF continues to be the waiver authority for conditions as listed in 6.4.1.***

For all other certification or waiver authority, see table A2.1.

EXHIBIT C

BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 36-3504

9 JULY 2013

Personnel

DISENROLLMENT OF UNITED STATES AIR FORCE ACADEMY CADETS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available on the e-Publishing website at **www.e-publishing.af.mil** for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AF/A1PT

Certified by: AF/A1P (Maj Mark Cipolla)

Pages: 11

Supersedes: AFI 36-2020, 22 April 1999

This Instruction implements AFPD 36-35, *United States Air Force Academy*, by providing direction for administratively disenrolling, separating, and discharging from the US Air Force Academy (USAFA), cadets who do not satisfy the conditions of enrollment and commissioning. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using AF Form 847, *Recommendation for Change of Publication.* Ensure that all records created as a result of processes prescribed in this publication are maintained IAW AFMAN 33-363, *Management of Records,* and disposed of IAW the Air Force Records Disposition Schedule (RDS) located at **https://www.my.af.mil/gcss-af61a/afrims/afrims**/. See Attachment 1 for a glossary of references and supporting information. This publication does not apply to Air Force Reserve Command (AFRC) Units. This publication does not apply to the Air National Guard (ANG).

This Instruction directs collecting and maintenance of information subject to the Privacy Act of 1974. System of Records Notice F036 USAFA applies.

SUMMARY OF CHANGES

This document supersedes AFI 36-2020, *Disenrollment of United States Air Force Academy Cadets.* It has been substantially revised and must be completely reviewed. Major changes include: removing provisions specifying disenrollment, separation and discharge criteria and procedures and instead delegating such authority to the USAFA Superintendent; delegating certain discharge characterization authority to the USAFA Superintendent; providing guidance for medical evaluations of cadets; and incorporating statutory changes pertaining to recoupment.

1. Overview. This Instruction provides direction pertaining to the disenrollment, resignation, and discharge of USAFA cadets and the collateral consequences of these actions, including enlisted service, monetary reimbursement for the cost of a USAFA education, and educational delay for the purpose of obtaining an alternative commissioning source.

2. Roles and Responsibilities.

2.1. The Secretary of the Air Force:

2.1.1. Has direct statutory authority pertaining to the disenrollment of USAFA cadets.

2.1.2. Or designee approves all disenrollments, transfers, and administrative discharges as well as procedures for affecting them. Hereafter, the phrase "decision authority" will substitute for the phrase "Secretary of the Air Force or designee" whenever it refers to final decision authority for individual disenrollment, resignation, and collateral consequence actions.

2.2. The Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR):

2.2.1. Serves as the agent of the Secretary and provides guidance, direction, and oversight for all matters pertaining to the formulation, review, and execution of plans, policies, and programs addressing cadet disenrollment, resignation, and associated collateral consequence actions.

2.2.2. Makes final decisions on individual disenrollment, resignation, and collateral consequence actions in those cases for which SAF/MR is the decision authority.

2.2.2.1. Notifies the Secretary of the Air Force in writing, and courtesy copies AF/A1, of intentions before taking any disenrollment action that is highly sensitive or has the potential for significant Congressional or public interest.

2.2.2.2. Makes recommendations to the decision authority on individual disenrollment, resignation, and collateral consequence actions in those cases for which there is a higher level decision authority.

2.2.2.3. Ensures each recommendation forwarded includes a rationale and a complete case file.

2.3. Deputy Chief of Staff for Manpower and Personnel and Services (AF/A1):

2.3.1. Formulates, reviews, and executes plans, policies, and programs addressing cadet disenrollment.

2.3.2. Ensures execution of orders for disenrolled cadets to perform enlisted service.

2.3.3. Reviews active duty obligations and assigns military grades to disenrolled cadets if the decision authority directs active duty service.

2.3.4. Ensures execution of an educational delay in processing a disenrolled cadet into the enlisted force for a period of 150 days, in those cases in which the collateral consequences decision authority orders an educational delay for the purpose of allowing the disenrolled cadet to obtain another commissioning source.

2.3.4.1. Approves or disapproves requests for extensions in the educational delay in 30-day increments, not to exceed a total of one year from the date of the original order.

2.3.4.2. Instructs the Air Force Personnel Center (AFPC) to call a disenrolled cadet to active duty who was granted educational delay but does not obtain an alternative commissioning source within the specified time.

2.3.5. Serves as liaison with other Services for disenrollment actions being taken on a cadet who had been an enlisted member in a Sister Service and was released from their obligation to that service contingent upon their acceptance and successful graduation and commissioning from USAFA.

2.4. Director, Air Force Review Boards Agency (AFRBA):

2.4.1. Makes final decisions on individual disenrollment, resignation, and collateral consequence actions in those cases for which AFRBA is the decision authority.

2.4.2. Notifies the Secretary of the Air Force, SAF/MR, and AF/A1 of intentions before taking any disenrollment action that is highly sensitive or has the potential for significant Congressional or public interest.

2.4.3. Makes recommendations to the decision authority on individual disenrollment, resignation, and associated collateral consequence actions in those cases for which there is a higher level decision authority.

2.4.4. Ensures each recommendation forwarded includes a rationale and the complete case file.

2.5. Superintendent, USAFA:

2.5.1. Ensures expeditious review and updating of cadet agreements to reflect current law and DoD and Air Force directives and policy.

2.5.2. Implements training and education programs to ensure cadets' awareness of and ability to comply with Air Force and USAFA standards of conduct, character, integrity, attitude, and deportment.

2.5.3. Prescribes criteria and procedures for reviewing cadet performance in the areas of academics, athletics/physical fitness, character development, military skills and potential, and summer training.

2.5.4. Prescribes criteria and procedures for cadets to remedy deficiencies when disenrollment is determined not to be appropriate without first attempting remedial actions to bring deficient cadets into compliance with standards.

2.5.5. Develops and implements (after coordination with, and approval of, AF/A1), cadet disenrollment and resignation criteria, standards, and procedures which:

2.5.5.1. Balance military, academic, physical fitness, and other training interests in expeditious processing with administrative due process appropriate to the nature of the action.

2.5.5.2. Upon implementation, are available in the USAFA listings on the Air Force Electronic Publications website.

2.5.6. Makes final decisions on individual disenrollment and resignation actions in those cases for which the Superintendent is the decision authority.

2.5.6.1. Notifies the Secretary of the Air Force, SAF/MR, AFRBA, and AF/A1 in writing of intentions before taking any disenrollment action that is highly sensitive or has the potential for significant Congressional or public interest.

2.5.6.2. Makes recommendations to the decision authority on individual disenrollment, resignation, and associated collateral consequence actions in only those cases for which the Superintendent is not the decision authority.

2.5.6.3. Ensures each recommendation forwarded to the decision authority includes a rationale and a complete case file and is forwarded to AFRBA.

2.5.7. Ensures complete records of final disposition are kept for all disenrollment, resignation, and collateral consequence decisions for no less than 3 years from the date of the disenrollment, in accordance with the Air Force record disposition schedule and Privacy Act System of Record Notice, F036 USAFA.

2.6. Commander, AFPC (AFPC/CC):

2.6.1. Determines and awards the service commitment for disenrolled cadets ordered to active enlisted service. The service commitment will not exceed 4 years and is reduced proportionately for each month active duty is served.

2.6.2. Monitors the status of disenrolled cadets who are granted an educational delay for the purpose of seeking an alternative commissioning source to ensure that their service commitment is satisfied.

3. Enrollment and Disenrollment Acknowledgements

3.1. Upon entry to the USAFA, basic cadets must sign an agreement that if they are subsequently disenrolled or resign during their second- or first-class year, they may be required to either:

3.1.1. Serve on active duty as an enlisted member in the Regular Air Force or Active or Reserve Component for a period of time not to exceed 4 years, or

3.1.2. Reimburse the for education costs when it is determined that fulfillment of the active duty service obligation by the cadet would not be in the best interest of the Air Force.

4. Conditions Supporting Disenrollment. Cadets are subject to involuntary disenrollment in one or more of the following circumstances:

4.1. Failure to comply with their USAFA enrollment agreement;

4.2. Lack of demonstrated potential for commissioned service;

4.3. Failure to abide by established Air Force or USAFA standards of conduct, character, integrity, or academic, military or physical fitness requirements; or

4.4. Are medically unsuited for continued military service.

5. Disenrollment Considerations. A decision to disenroll a cadet or accept a cadet's resignation constitutes a finding the cadet has broken the agreement to complete the course of

instruction at USAFA. Disenrollment because of medical disqualification not due to the cadet's misconduct or fraudulent concealment of medical conditions ordinarily will not be found to constitute a breach of the agreement.

6. Collateral Consequences Considerations.

6.1. Active duty service is the primary means of reimbursement for a cadet's education at USAFA; however, monetary reimbursement or an educational delay for the purpose of allowing the disenrolled cadet to obtain an alternative commissioning source can be considered under appropriate circumstances.

6.2. Cost of education debts are determined by USAFA/FMA and forwarded to the Defense Finance and Accounting Service (DFAS) to establish the accounts receivable. Monetary accounts receivables for educational costs are established by DFAS for appropriate collection action.

7. Disenrollment/Discharge Resulting in Entry-Level Discharge Characterizations

7.1. Basic cadets engaged in Basic Cadet Training (BCT) and fourth-class cadets, prior to issuance of their first academic progress report and still within 180 days of entering military service, who are determined by medical personnel to have a pre-existing (EPTS) disqualifying medical condition not compatible with continued military service will be disenrolled from USAFA and discharged from the Air Force with an Entry-Level characterization. If a disqualifying medical condition is sustained, or if a reported pre-existing condition was waived and the condition is aggravated during BCT, or at some time prior to the cadet's first academic progress report, the cadet is subject to a medical evaluation board (MEB).

7.2. Basic cadets who submit a voluntary resignation during BCT receive an Entry-Level discharge characterization unless they have prior enlisted service or have graduated from the USAFA Preparatory School, in which case they receive a discharge characterization IAW paragraph 12 below.

8. Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB). When a question arises about a cadet's medical qualification for continued service or commissioning, medical personnel evaluate the cadet using the medical standards set forth in DoDI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*; and AFI 48-123, *Medical Examinations and Standards.* If medical personnel determine the cadet does not meet continuation standards, an MEB will be convened under procedural guidance outlined in AFI 41-210, *TRICARE Operations and Administration Functions*, AFI 10-203, *Duty Limiting Conditions*, AFPD 36-32, *Military Retirements and Separations* and AFI 36-3212, *Physical Evaluation for Retention, Retirement and Separation.*

9. Active Duty Service Commitments (ADSC), Grade Awards and Educational Delays.

9.1. Enlisted grade is based on the cadet's class year at the time the disenrollment conduct occurred or the resignation was submitted and not based on the cadet's class year at the time of the final action. Disenrolled cadets are awarded the following grades:

9.1.1. Second class--Airman First Class (E-3). (*EXCEPTION:* The cadet will revert to the highest pay grade held during enlisted service prior to entering USAFA if that pay grade was higher than E-3.)

9.1.2. First class--Senior Airman (E-4). These individuals must qualify at the five-skill level Air Force Specialty Code (AFSC) to retain the grade of E-4. (*EXCEPTION:* The cadet will revert to the highest pay grade held during enlisted service prior to entering USAFA if that pay grade was higher than E-4.)

9.2. A disenrolled cadet may request an educational delay in fulfilling their service commitment for the purpose of obtaining a commission by means of an alternative source.

9.3. The disenrolled cadet will normally be called to active duty not later than 30 days after the receipt of the decision authority's order directing enlisted service as the collateral consequence of disenrollment.

9.4. When the Superintendent concludes a cadet is not qualified for graduation and commissioning, the Superintendent will determine the cadet's status while the case is pending disposition.

10. Disenrolling Cadets with Prior Service.

10.1. Cadets who enter USAFA from the regular or reserve component of any military service and who fail to fulfill their USAFA enrollment agreement may incur an active duty service commitment (ADSC) in return for their education at USAFA. Subject to the subparagraphs below, a disenrolled cadet with a prior service commitment will serve that commitment concurrently with any USAFA commitment with the longer of the two taking precedence.

10.2. Cadets who were members of a regular or reserve component before enrollment and are disenrolled before they begin their second class year academics, return to their former military status to complete any remaining service commitment.

10.2.1. If the commitment is to the Air Force and is within 1 year of ending or has ended by the separation date, the cadet is reassigned to the Reserves (not extended active duty).

10.2.2. If the cadet's prior service was not in the Air Force, USAFA notifies AF/A1PT who reports the disenrollment and removal from cadet status to the proper Service to coordinate disposition.

10.3. Cadets who were members of a Regular or Reserve component before enrollment and have begun their second class year academics are disenrolled in the same manner as cadets with no prior service, except under the following circumstances:

10.3.1. If the prior service commitment extends beyond the period of active duty commitment the cadet incurs according to paragraph 9, the cadet then completes the prior service obligation unless the decision authority determines that a different collateral consequence is more appropriate because of the circumstances surrounding the disenrollment.

10.3.2. If the prior service did not take place in the Air Force and the disenrolled cadet has a remaining service commitment from the prior service, USAFA notifies AF/A1PT, who reports the disenrollment and removal from cadet status to the proper Service and coordinates disposition.

10.3.2.1. If the cadet's previous Service elects not to have the cadet return to complete any outstanding obligations to them, the cadet is separated from cadet status in the same manner as a cadet with no prior service obligation.

10.3.2.2. If the cadet's previous Service elects to have the cadet return to complete any outstanding obligations to them, the disenrolled cadet is separated from cadet status and returned to service in accordance with the prior Service's instructions.

11. Disenrolling Foreign Cadets. USAFA will notify AF/A1, who in turn will notify SAF/IA upon initiation of disenrollment actions on a foreign cadet for coordination with home nation government.

12. Service Characterization. The disenrollment decision authority determines the cadet's discharge characterization according to the following standards:

12.1. Honorable. This is the highest character of discharge. It should be awarded when the quality of the cadet's service has met Air Force standards of acceptable conduct or when the cadet's record is otherwise so meritorious that any other characterization would be inappropriate.

12.2. General Under Honorable Conditions (General). This service characterization is appropriate when a cadet's service has been honest and faithful but contains significant negative aspects which outweigh the positive. The decision authority may direct this type of discharge if the military record is not sufficiently meritorious to warrant an honorable discharge but does not warrant a discharge under other than honorable conditions.

12.3. Under Other Than Honorable Conditions (UOTHC). This is the least favorable type of administrative discharge. The decision authority may direct a UOTHC discharge when there exists a pattern of behavior or one or more acts or omissions that constitute a significant departure from the conduct expected of officer candidates.

12.4. Entry-Level. Assign an Entry-Level characterization when a cadet is disenrolled and discharged within 180 days of taking the oath of appointment, unless they have prior enlisted service or have graduated from the USAFA Preparatory School, and for certain EPTS-related disenrollments of Basic Cadets in BCT and of certain 4th-class cadets as described above.

13. Voluntary Resignations.

13.1. All resignations tendered in accordance with this paragraph are voluntary.

13.2. These include, but are not limited to, such reasons as change of career goals, personal reasons, or difficulty in acclimating to a military environment.

13.3. They do not include resignations tendered in the situations described in paragraphs 13.3.1 and 13.3.2. Tenders of resignation of this nature will not be acted upon until the command has determined paragraphs 13.3.1 and/or 13.3.2 no longer apply.

13.3.1. The individual is under preferred charges under the Uniform Code of Military Justice (UCMJ) or under consideration for or the subject of an investigation that could lead to a court-martial or disenrollment action under this AFI. See paragraphs 14 and 15 for tenders of resignation for the good of the service or resigning instead of further disenrollment procedures.

13.3.2. If the individual submitting the voluntary resignation is under consideration for or is the subject of an investigation that could lead to involuntary disenrollment under paragraphs 4.1 – 4.3. See paragraph 14 for tenders of resignation instead of further disenrollment procedures.

13.4. Cadets must tender voluntary resignations to the Superintendent in writing.

13.5. The decision authority determines whether to accept a cadet's resignation and assigns the service characterization.

13.6. Acceptance of a tender of voluntary resignation does not negate the applicability of paragraphs 6, 9, and 10.

13.7. The Superintendent may permit cadets who have tendered voluntary resignations to withdraw them if the Superintendent determines withdrawal of the resignation is in the best interest of the Air Force.

14. Resigning Instead Of Further Disenrollment Action.

14.1. Cadets under consideration for, or who are the subject of, an investigation that could lead to involuntary disenrollment under paragraphs 4.1 – 4.3 may tender resignations in lieu of further disenrollment action.

14.2. Cadets resigning in lieu of further disenrollment action may receive an honorable, general, or under other-than-honorable-conditions discharge characterization as determined by the decision authority. The Superintendent may establish procedures permitting cadets to tender resignations conditioned on service characterization that includes the Superintendent's authority to deny such conditional resignations.

14.3. The decision authority determines whether to accept a cadet's resignation and assigns the appropriate service characterization.

14.4. Acceptance of a tender of resignation in lieu of further disenrollment action does not negate the applicability of paragraphs 6, 9, and 10.

14.5. The Superintendent may permit cadets who have tendered resignations in lieu of further disenrollment action to withdraw them if the Superintendent determines withdrawal of the resignation is in the best interest of the Air Force.

14.6. Cadets must tender resignations requests to the Superintendent in writing.

15. Resigning for the Good of the Service. Cadets who are subject to trial by court-martial may tender a resignation for the good of the service under the provisions of AFI 36-3207, *Separating Commissioned Officers*, (but see *References*, Atch. 1) and AFI 51-201, *Administration of Military Justice*.

16. Fulfilling Service Commitments. Cadets whose resignations are approved must fulfill their ADSC and/or obligations to reimburse the Government for education costs per AFI 36-2002, *Regular Air Force and Special Category Accessions*. A cadet ordered to active duty has a military service obligation equivalent to the period for which they are ordered to active duty or to the reserve components.

17. Conducting Additional Investigations. If the Superintendent decides to conduct an investigation after a resignation requiring decision by a higher authority has been forwarded, the Superintendent:

17.1. Informs AF/A1 of the reasons by message, and

17.2. Requests the decision authority delay action until the investigation is complete and the Superintendent can forward recommendations based on the results of the investigation.

18. Reporting Disenrollments.

18.1. USAFA will submit Air Force Cadet Wing End Strength to the Manpower Program Development Division (AF/A1MP) and the Accessions and Training Management Division (AF/A1PT) no later than the fifth of each month.

18.2. USAFA will provide the AFRBA a quarterly listing of disenrollment actions (includes resignations under paragraphs 14 and 15) that are initiated or finalized during the respective quarter. This listing need only include the cadet name, class year, basis for disenrollment, status or final disposition, and a short summary of the facts supporting the action.

DARRELL D. JONES, Lieutenant General, USAF
Deputy Chief of Staff, Manpower, Personnel and Services

Attachment 1

GLOSSARYOFREFERENCESANDSUPPORTINGINFORMATION

References

10 U.S.C. §2005

10 U.S.C. §8013

10 U.S.C. §9348

37 U.S.C. §303a(e)(1)

AFPD 36-35, *United States Academy*, 1 February 2007

AFPD 36-32, *Military Retirements and Separations*, 14 July 1993

AFI 36-3206, *Separating Commissioned Officers*, 9 June 2004

AFI 36-3207, *Separating Commissioned Officers*, 9 July 2004

AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*, 2 February 2006

AFI 48-123, *Medical Examinations and Standards*, 24 September 2009

AFI 41-210, *TRICARE Operations and Patient Administration Functions*, 6 June 2012

AFI 51-201, *Administration of Military Justice*, 21 December 2007

AFI 36-2002, *Regular Air Force and Special Category Accessions*, 7 April 1999

AFI 10-203, *Duty Limiting Conditions*, 25 June 2010

AFMAN 33-363, *Management of Records*, 1 March 2008

Forms Prescribed. No forms are prescribed by this publication.

Forms Adopted. AF Form 847

Abbreviations and Acronyms

ADSC—Active Duty Service Commitment

AETC—Air Education and Training Command

AFPC—Air Center

AFSC—Air Force Specialty Code

EPTS—Existed Prior to Service

IAW—In Accordance With

MEB—Medical Evaluation Board

SECAF—Secretary of the Air Force

UCMJ—Uniform Code of Military Justice

UOTHC—Under Other than Honorable Conditions

Terms

Collateral Consequences—Incidents of disenrollment flowing from disenrollment. Includes reimbursement of educational expenses financially or through enlisted service, and educational delay.

Discharge—Acompleteseverancefrommilitarystatus,activeorotherwise.

Disenrollment—Termination ofcadetstatus. Disenrollmentisaconsequenceof the decision authority's determinationthatacadetisnotqualifiedforcommissioning or graduation. Acadetisdisenrolledwhen the decision authority decides the cadet is unfit or unsuitable for graduation and/or commissioning, or otherwise fails to meet graduation and/or commissioning standards, approves the cadet's resignationor the cadet is dismissed in accordance pursuant to sentence of a general courtmartial. Removalfromthecadetwing pendingdisenrollmententailslossofentitlementtoparticipateinacademic,athletic,morale,andmilitary programs,butdoesnotinitselfendcadetstatusorothermilitaryobligations,andsomeorallofitsnormaleff ectsasdescribedabovemaybesuspendedbytheSuperintendent.

Resignation—Arequestbyacadetfor removal from cadet status. Ifaresignationisapproved,thecadetis either disenrolled and removed from cadet status or discharged.

EXHIBIT D

Department of Defense

INSTRUCTION

NUMBER 6485.01
June 7, 2013

USD(P&R)

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

References: See Enclosure 1

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

2. APPLICABILITY. This instruction applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

3. POLICY. It is DoD policy to:

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

b. Periodically screen Service members for HIV infection.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

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

7. EFFECTIVE DATE. This instruction:

a. Is effective June 7, 2013.

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

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

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1. References
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," April 28, 2010, as amended
(d) DoD Instruction 5025.01, "DoD Directives Program," September 26, 2012
(e) DoD Directive 6490.02E, "Comprehensive Health Surveillance," February 8, 2012
(f) DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," January 3, 2006
(g) DoD Instruction 6490.03, "Deployment Health," August 11, 2006
(h) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011
(i) DoD 6025.13-R, "Military Health System (MHS) Clinical Quality Assurance Program (CQA) Regulation," June 11, 2004
(j) DoD Instruction 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010
(k) DoD Instruction 1332.38, "Physical Disability Evaluation," November 14, 1996, as amended
(l) Section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986
(m) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
(n) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003

ENCLOSURE 2

RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

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

ENCLOSURE 3

PROCEDURES

1. TESTING AND SCREENING

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

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

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

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

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

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

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

2. MANAGEMENT

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

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

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

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

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

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

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

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

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

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

PART II. DEFINITIONS

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

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

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

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

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

EXHIBIT E

BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 44-178

4 MARCH 2014
Certified Current 28 June 2016
Medical

HUMAN IMMUNODEFICIENCY VIRUS PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements AFPD 44-1, *Medical Operations*, and Department of Defense (DoD) Instruction 6485.01, *Human Immunodeficiency Virus*, June 7, 2013. It outlines the Air Force Human Immunodeficiency Virus (HIV) Program including responsibilities and procedures for identification, surveillance, and administration of Active Duty Air Force personnel. The Air National Guard (ANG) and Headquarters Air Force Reserve Command (HQ AFRC) utilize this instruction along with supplements to provide specific guidelines for the administration of Air Reserve Component (ARC) personnel infected with HIV. Headquarters Air Reserve Personnel Center (HQ ARPC) utilizes AFI 44-175 as guidance for Individual Mobilization Augmentees (IMAs), with local MTFs as the notifying agent. This instruction requires collecting and maintaining information protected by the Privacy Act of 1974. This is authorized by 10 U.S.C., Chapter 55, *Medical and Dental Care*, 10 U.S.C., Sec. 8013, *Power and Duties of the Secretary of the Air Force*, and Executive Order 9397 (SSN) as amended by Executive Order 13478, Amendments to Executive Order 9397 Relating to Federal Agency Use of Social Security Numbers, November 18, 2008. Systems Record Notices F044 AF SG E, *Electronic Medical Records System*, and R, *Reporting of Medical Conditions of Public Health and Military Significance*, apply. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual (AFMAN) 33-363, Management of Records, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS).

Send comments and suggested improvements on AF Form 847, **Recommendation for Change of Publication**, through channels, to AFMSA/SG3PM. See **Attachment 1** for a glossary of

references, abbreviations, acronyms, and terms. This publication may be supplemented at any level, but all direct Supplements must be routed to the OPR of this publication for coordination prior to certification and approval. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, Publications and Forms Management, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include condensed sections describing the requirements for a positive HIV test and algorithms for determining HIV infection which reference current guidelines by the American Public Health Laboratories (APHL) and Centers for Disease Control (CDC). The location of the USAF HIV Medical Evaluation Unit was updated to San Antonio Military Medical Center (SAMMC) and the location of HIV laboratory testing was updated to the USAF School of Aerospace Medicine (USAFSAM) HIV Testing Services, Wright-Patterson Air Force Base. The clinical evaluation visit structure was modified, with HIV evaluations performed at SAMMC for initial visits, followed by a second visit in 6 months, then yearly thereafter while the patient remains on active duty (AD) status. Interim clinical visits will be performed as necessary in the local area based on recommendations from the USAF HIV Medical Evaluation Unit. The sections detailing the components of HIV clinical evaluations have been condensed with all elements of HIV clinical evaluations to be performed according to current clinical guidelines.

Chapter 1

ROLES AND RESPONSIBILITIES

1.1. HQ USAF/SG. Provides facilities, manpower, and funds to collect HIV testing specimens of Air Force (AF) personnel, to medically evaluate all HIV positive AD members including IMAs, and to ensure spouses and contacts of HIV infected AD members are notified, counseled, and tested appropriately.

1.2. HQ AFRC/SG. Ensures reserve personnel are HIV tested and spouses and contacts of HIV infected reserve personnel are notified appropriately.

1.3. HQ ANG/SG. Ensures ANG personnel are HIV tested and spouses and contacts of HIV infected ANG personnel are notified appropriately.

1.4. HQ AFMC/SG. Provides facilities, funds, and manpower to the USAFSAM HIV Testing Services to perform HIV testing and epidemiological analysis of all HIV tests performed on ADAF personnel and their dependents. Provides support to the DoD Serum Repository.

1.5. HQ AETC/SG. Provides facilities, funds, and manpower to medically evaluate all HIV positive ADAF members.

1.6. USAF HIV MEDICAL EVALUATION UNIT. Located in the Joint Infectious Disease Service at SAMMC, medically evaluates all ADAF HIV positive members initially, at 6 months, and then every 12 months thereafter while on active duty. (T-1)

Chapter 2

HIV PROGRAM

2.1. General. The AF tests all members for human immunodeficiency virus, medically evaluates all AD infected members, and educates members on means of prevention.

2.2. Populations Tested.

2.2.1. Accessions. All applicants for enlistment or appointment to the ADAF or ARC are screened for evidence of HIV infection (**Attachment 3**). Applicants infected with HIV are ineligible for enlistment or appointment to the ADAF and the ARC. Waiver for HIV infection is not authorized.

2.2.2. ADAF personnel. All ADAF personnel are screened for serological evidence of HIV infection every two years, preferably as part of their Preventive Health Assessment (PHA). They are also tested for clinically indicated reasons, when newly diagnosed with active tuberculosis, during pregnancy, when diagnosed with a sexually transmitted infection (STI), upon entry to drug or alcohol treatment programs, or prior to incarceration. HIV testing is conducted IAW **Attachment 3**. (T-1)

2.2.3. ARC personnel. Air Force Reserve personnel are screened for serological evidence of HIV infection every two years, preferably during their PHA (Preventive Health Assessment). ARC members will have a current HIV test within two years of the date on which they are called to active duty for 30 days or more.HIV testing is conducted IAW **Attachment 3**. (T-1)

2.2.4. DoD Civilians. DoD Civilian employees are tested for serological evidence of HIV to comply with host nation requirements for screening of DoD employees (**Attachment 6**) and after occupationally related exposures. (T-1)

2.3. Initial Procedures for Positive Tests. All ADAF personnel testing positive are counseled by a physician regarding the significance of a positive test. They are given information on modes of transmission, appropriate precautions to mitigate transmission, and prognosis. ADAF members are administered an order to follow preventive medicine requirements as described in **Attachment 7**. ARC members will also be administered this order. The preventive medicine requirements/order will not be delayed pending any administrative action. All eligible beneficiaries are offered counseling. Contacts of HIV-infected members are notified of potential exposure to HIV infection according to state or local law. (T-0)

2.4. Clinical Evaluation, to Include Evaluation for Continued Military Service. All ADAF members, as well as ARC members on extended active duty, who test positive for HIV are referred to SAMMC for medical evaluation. Per AFI 48-123 and AFI 41-210, HIV-positive personnel must undergo medical evaluation for the purpose of determining status for continued military service. ARC members who are not on extended active duty or who are not on full-time National Guard duty, and who show serologic evidence of HIV infection, will be referred for a medical evaluation of fitness for continued service in the same manner as service members with other chronic or progressive illnesses in accordance with DoDI 1332.38. In the case of an ANG member, it is only required if the state identifies a nonmobility, nondeployable position in which the member can be retained. All ADAF members will have an initial evaluation at SAMMC, followed by a visit at 6 months, then yearly thereafter while remaining on AD status. ARC and

ANG members whose condition is determined to meet Line of Duty requirements may have initial and/or annual HIV evaluations performed at regional military facilities. ARC and ANG members not meeting Line of Duty requirements will have an initial evaluation by a civilian HIV specialist. The medical evaluation follows the standard clinical protocol outlined in **Attachment 8** and utilizes procedures for evaluating T-helper cell counts described in **Attachment 12**. ARC members not on extended active duty must obtain a medical evaluation that meets the requirements of **Attachment 8** from their civilian healthcare provider (in the case of the ANG, only if the state identifies a nonmobility, nondeployable position in which the member can be retained). An epidemiological assessment (including sexual contacts and history of blood transfusions or donations) is conducted to determine potential risk of HIV transmission (see **Attachment 11**). (T-1)

2.4.1. Outcome of Evaluation for Continued Military Service. HIV seropositivity alone is not grounds for medical separation or retirement for ADAF members. Members shall be retained or separated as outlined in **Attachment 9**. (T-1)

2.4.2. Periodic Re-evaluation. HIV infected ADAF members retained on active duty and ARC members retained in the Selected Reserve must be medically evaluated annually at SAMMC. Such personnel must be assigned within the continental United States (CONUS). Alaska, Hawaii, and Puerto Rico are also acceptable. ARC HIV infected members may not be deployed outside of CONUS (except for Alaska, Hawaii, and Puerto Rico). HIV-infected members shall not be assigned to OCONUS mobility positions, and those on flying status must be placed on Duty Not Including Flying (DNIF) status pending medical evaluation/waiver determination. Waivers are considered using normal procedures established for chronic diseases. Aeromedical waivers are considered according to the Aerospace Medicine Waiver Guide. Members on the Personnel Reliability Program (PRP) or other security sensitive positions shall evaluated for suspension or temporary decertification during medical evaluation, as determined by their Certifying Official/Unit Commander on the advice of a Competent Medical Authority. The Secretary of the Air Force may, on a case-by-case basis, further limit duties and assignment of members to protect the health and safety of the HIV-infected member or other members. Submit such requests to Office of the Secretary of the Air Force, Air Force Pentagon,Washington, DC 20330-1670. (T-1)

2.5. Limitations of Use of Information. Commanders and other personnel comply with limitations on the use of information obtained during the epidemiological assessment of HIV-infected members as outlined in **Attachment 10**. (T-1)

2.6. Public Health. Provides HIV education to all ADAF members, offers education to other eligible beneficiaries, maintains a list of HIV positive personnel to be gained, reports to gaining bases departing HIV positive personnel, and educates HIV positive members and their dependents. (T-1)

2.7. USAFSAM. USAFSAM performs HIV testing (PHE) of submitted specimens and conducts epidemiological surveillance (PHR) of HIV infection in Air Force members and dependents. (T-1)

2.8. AF Blood Centers. AF Blood Centers follow policies of the Armed Services Blood Program Office, Food and Drug Administration (FDA), and the accreditation requirements of the American Association of Blood Banks (AABB). (T-0)

2.9. Combat Zone Procedures. Routine HIV testing is suspended in declared combat zones, defined as those areas where hostile pay is authorized.

2.10. Work Restrictions. Force-wide, HIV-infected employees are allowed to continue working as long as they are able to maintain acceptable performance and do not pose a safety or health threat to themselves or others in the workplace. If performance or safety problems arise, managers and supervisors address such problems using existing personnel policies and instructions. HIV-infected healthcare workers, however, should be relieved from patient care responsibilities until an expert review panel has met to advise the healthcare worker on work restrictions. Recommendations to the panel will be made by HIV treatment experts during the individual's initial HIV evaluation at SAMMC in accordance with the most recent guidelines from the Centers for Disease Control and Society for Health Care Epidemiology of America. The panel should be encouraged to contact SAMMC for advice (via telephone conference call) to ensure organizational consistency. (T-1)

Chapter 3

HIV TESTING MEASUREMENT

3.1. HIV Testing Measurement. The AF's goal is to reduce the incidence of HIV infection in its personnel. USAFSAM tracks trends of HIV incidence in AF members. AF labs that do their own HIV testing must communicate test results and ship corresponding serum specimens to USAFSAM so they may ship samples to the DoD serum repository, and track trends. (T-1)

Chapter 4

FORMS

4.1. Forms. AF Form 1762, *HIV Log/Specimen Transmittal*, will be used for requesting HIV testing and specimen transmittal for those sites that do not have CHCS access (see **Attachment 4**). AF Form 3844, *HIV Testing Notification Form*, will be used to notify personnel of required HIV testing. AF Form 3845, *Preventive Medicine Counseling Record*, will be used to record counseling provided for HIV positive individuals. AF Form 74, *Communication Status Notice/Request*, is sent to MTF/CCs and Reserve Medical Unit (RMU)/CCs along with a copy of the patient's positive HIV testing screen and confirmation testing results. The MTF/CC and RMU/CC will document on AF Form 74 that the patient has been notified of the positive HIV results, then return the form to USAFSAM. Positive HIV results will not be finalized until USAFSAM/PHE receives the AF Form 74. (T-1)

THOMAS W. TRAVIS
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References.

Title 29, United States Code, Section 794, *Non-Discrimination Under Federal Grants and Programs*, current edition

DoD Directive 1332.18, *Separation or Retirement for Physical Disability*, 4 November 1996

DoD Instruction 1332.38, *Physical Disability Evaluation*, *CH 2*, 10 April 2013

DoD Instruction 6485.01, *Human Immunodeficiency Virus,* 7 June 2012

DoD Regulation 5210.42, *Nuclear Weapons Personnel Reliability Program,* 16 July 2012.

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SHEA. Guideline for Management of Healthcare Workers Who Are Infected with Hepatitis B Virus, Hepatitis C Virus,and/or Human Immunodeficiency Virus Infection Control and Hospital Epidemiology 2010;. 31, no. 3.

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Adopted Forms.

AF Form 1762, HIV Log/Specimen Transmittal

AF Form 3844, HIV Testing Notification Form

AF Form 3845, Preventive Medicine Counseling Record

AF Form 74, Communication Status Notice/Request

Abbreviations and Acronyms.

AABB—American Association of Blood Banks

ADAF—Active Duty Air Force

AETC—Air Education and Training Command

AFMC—Air Force Materiel Command

AFMOA—Air Force Medical Operations Agency

AFMOA/SGOC—Air Force Medical Operations Agency, Surgeon General's Office of Consultants

AFPC—Air Force Personnel Center

AFPC/DPANM—Air Force Personnel Center/Medical Retention Standards Branch

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AIDS—Acquired Immunodeficiency Syndrome

ANGB—Air National Guard Bureau

APHL—American Public Health Laboratories

ARC—Air Reserve Component (Air Force Reserve and Air National Guard)

ASD—Assistant Secretary of Defense

CDC—Centers for Disease Control and Prevention

CHCS—Composite Healthcare System

CHN—Community Health Nurse

CONUS—Continental United States

COT—Consecutive Overseas Tour

CPO—Civilian Personnel Office

DAF—Department of the Air Force

DBMS—Director, Base Medical Services

DoD—Department of Defense

DoDSR—Department of Defense Serum Repository

DNIF—Duty Not Including Flying

DSN—Defense Switched Network

FDA—Food and Drug Administration

FM—Flight Medicine

FM & P—Force Management and Personnel

FMP—Family Member Prefix

HBV—Hepatitis B virus

HIV—Human Immunodeficiency Virus (the virus that causes AIDS)

HQ AETC—Headquarters Air Education and Training Command

HQ AFRC/SG—Headquarters Air Force Reserve Command Surgeon

HQ ANG/SG—Headquarters Air National Guard Command Surgeon

HQ USAF—Headquarters US Air Force

ICD-9—International Classification of Diseases, Revision 9

IMA—Individual Mobilization Augmentee

I-RILO—Initial Review in Lieu of Medical Board

MAJCOM—Major Command

MEB—Medical Evaluation Board

MTF/CC—Medical Treatment Facility Commander

MPF—Military Personnel Flight

MTF—Medical Treatment Facility

NGB—National Guard Bureau

OB—Obstetrics

OI—Opportunistic Infection

OS—Overseas

OSHA—Occupational Safety and Health Association

OTS—Officer Training School

PCS—Permanent Change of Station

PE—Physical Examination

PES—Physical Examination Section

PH—Public Health

PQAM—Program Quality Assurance Monitor

PRP—Personnel Reliability Program

ROTC—Reserve Officer Training Corps

SAF—Secretary of the Air Force

SAMMC—San Antonio Military Medical Center

SF—Standard Form

SG—Surgeon General

SHEA—Society for Healthcare Epidemiology of America

SSN—Social Security Number

STI—Sexually Transmitted Infection

TDY—Temporary Duty

USA—United States Army

USCG—United States Coast Guard

USMC—United States Marine Corps

USN—United States Navy

UCMJ—Uniform Code of Military Justice

USAFSAM—United States Air Force School of Aerospace Medicine

USUHS—Uniformed Services University of the Health Sciences

Terms.

Air Reserve Component—Air Force Reserve and Air National Guard components of the Air Force

Department of Defense Civilian Employees—Current and prospective DoD US civilian employees. Does not include members of the family of DoD civilian employees, employees of, or applicants for, positions with contractors performing work for DoD, or their families.

Enzyme Linked Immunosorbent Assay—A screening test read as ‘reactive’ if the results are above a calculated cutoff.

Epidemiological Assessment—The process by which personal and confidential information on the possible modes of transmission of HIV are obtained from an HIV-infected person. This information is used to determine if previous, present, or future contacts of the infected individual are at risk for infection with HIV and to prevent further transmission of HIV.

Host Nation—A foreign nation to which DoD US civilian employees are assigned to perform their official duties.

Human Immunodeficiency Virus—The virus that causes AIDS.

Positive—A true positive test is an indicator of a condition being present

Reactive—Reacts with the reagent antibody test to produce a visible result

Serologic Evidence of HIV Infection—A reactive result given by a FDA approved serologic test for HIV detection, such as an enzyme-linked immunosorbent assay (ELISA) or

Chemiluminescent Immunoassay (ChLIA) that is confirmed in by additional testing in a validated testing algorithm, for example by a diagnostic HIV Western Blot immunoelectrophoresis. For Western Blot tests with indeterminate results, an alternative FDA approved test can be used to resolve indeterminates such as a viral load-based assay (APTIMA).

Western Blot Test—A qualitative assay for the detection and identification of antibodies of HIV-1 contained in human serum. It is intended for use with persons of unknown risk as an additional more specific test on human serum specimens found to be repeatedly reactive using a screening procedure such as ELISA.

Attachment 2

PROCEDURES FOR SCREENING APPLICANTS

A2.1. Screen applicants to the USAF or ARC for serologic evidence of HIV infection. Test and interpret results, using the procedures in **Attachment 3**. Counsel applicants on the significance of test results and the need to seek treatment from a civilian physician. (T-1)

A2.2. Screen applicants for enlisted service at the Military Entrance Processing Stations (MEPS) or the initial point of entry to military service. Applicants who enlist under a delayed enlistment program who exhibit serologic evidence of HIV infection before entry on active duty may be discharged due to erroneous enlistment. (T-1)

A2.3. Screen applicants accepted for the Air Force Academy as part of the processing for entry into the Academy and again as part of their medical screening prior to appointment as officers. Screen other officer candidates during their preappointment or precontracting physical examination. (T-1)

A2.4. Screen applicants for ARC during the normal entry physical examinations or in the preappointment programs established for officers. Those individuals with serologic evidence of HIV infection, who must meet accession medical fitness standards to enlist or be appointed, are not eligible for service with the ARC. (T-1)

A2.5. Take the following actions on officer applicants who are ineligible for appointment due to serologic evidence of HIV infection:

A2.5.1. Disenroll enlisted members who are candidates for appointment through Officer Training School (OTS) programs immediately from the program. If OTS is the individual's initial entry training, discharge the individual. If the sole basis for discharge is serologic evidence of HIV infection, issue an honorable or entry-level discharge, as appropriate. A candidate who has completed initial entry training during the current period of service before entry into candidate status shall be administered in accordance with Service directives for enlisted personnel. (T-1)

A2.5.2. Disenroll individuals in preappointment programs, such as Reserve Officer Training Corps (ROTC) and Health Professions Scholarship Program (HPSP) participants. The head of the Military Service concerned, or the designated representative, may delay disenrollment until the end of the academic term in which serologic evidence of HIV infection is confirmed. Disenrolled participants retain any financial support through the end of the academic term in which the disenrollment takes place. Financial assistance received in these programs is not subject to recoupment, if the sole basis for dis-enrollment is serologic evidence of HIV infection. (T-1)

A2.5.3. Separate Air Force Academy cadets and personnel attending the Uniformed Services University of the Health Sciences (USUHS) from the Academy or USUHS and discharge them. The superintendent of the Academy may delay separation to the end of the current academic year. A cadet granted such a delay in the final academic year, who is otherwise qualified, may graduate without commission and then is discharged. If the sole basis for discharge is serologic evidence of HIV infection, issue an honorable discharge. (T-1)

A2.5.4. Disenroll commissioned officers in DoD-sponsored professional education programs leading to appointment in a professional military specialty (including medical, dental, chaplain, and legal or judge advocate) from the program at the end of the academic term in which serologic evidence of HIV infection is confirmed. Except when laws specifically prohibit it, waive any additional service obligation incurred by participation in such programs; do not recoup any financial assistance received in these programs. Apply the time spent by the officers in these programs towards satisfaction of any preexisting service obligation. (T-1)

A2.5.5. Counsel people disenrolled from officer programs who are to be separated; include preventive medicine counseling and advise the individual to seek treatment from a civilian physician. (T-1)

Attachment 3

AIR FORCE HIV TESTING PROCEDURES

A3.1. Responsibilities:

A3.1.1. Medical Treatment Facility Commander (MTF/CC). Is responsible for the HIV testing program. Appoints an HIV designated physician (and one or more alternates, if alternates are desired); ensures HIV positive individuals are notified and counseled as soon as possible following receipt of the positive test result; and ensures AD members are referred to SAMMC within 60 days of receipt of the HIV positive results notification from the USAFSAM HIV Testing Services to the base. Reserve medical unit commanders will immediately notify wing/unit commanders of any positive HIV test results. (T-1)

A3.1.2. Clinical Laboratory Manager**.** Draws, processes, and ships specimens for HIV testing. All specimens for HIV testing should be sent to USAFSAM HIV Testing Services, Epidemiology Laboratory Service, USAFSAM/PHE, 2510 Fifth Street, Bldg 20840, Wright-Patterson, OH 45433-7951 (DSN 798-4140). If, because of time considerations, local contract HIV testing is done for needlestick exposure, the laboratory manager must also ship a corresponding serum specimen, with HIV test request, to USAFSAM HIV Testing Services. If testing is done by an approved USAF laboratory, the laboratory manager must also ship corresponding serum specimen and results to USAFSAM HIV Testing Services. Upon completion of testing, USAFSAM HIV Testing Service will ship AD, Guard and Reserve samples to the Department of Defense Serum Repository (DoDSR). (T-1)

A3.1.3. Primary Care Management Team**.** Ensures HIV testing is accomplished in conjunction with appropriate Preventive Health Assessment or physical examinations (as described in paragraph **A3.2**). (T-1)

A3.1.4. Public Health (PH). Coordinates with MTF/CC's designee to ensure proper notification of the individual member. Is responsible for monitoring HIV positive ADAF members. Receives and reports to gaining public health personnel when HIV positive personnel are transferred. Informs the requesting laboratory of positive results so they can close out the test status in the computer system. The SAMMC HIV community liaison nurse performs additional case contact interviews, epidemiological follow-ups, and disease reporting procedures during SAMMC HIV evaluation visits. (T-1)

A3.1.5. HIV Testing Point of Contact. MTF shipping and receiving technician is responsible for shipping specimens; identifying supply deficiencies; maintaining results; and acting as the liaison with USAFSAM HIV Testing Services. (T-1)

A3.1.6. Civilian Personnel Office (CPO). Notifies by letter the clinical laboratory manager of any Department of the Air Force civilian employee requiring HIV testing. (T-1)

A3.1.7. Major Commands (MAJCOM). Deputy Command Surgeon (MAJCOM/SGP) or designee acts as liaison between USAFSAM HIV Testing Services and MTFs within the command.

A3.1.8. **USAFSAM**. Monitors and ensures that all active duty, guard and reserve positive HIV tests, as well as positive tests on dependants in the San Antonio area are reported to the HIV Program at SAMMC. Ensures that DoD mandated epidemiological studies are

accomplished on a periodic basis. The USAF HIV Medical Evaluation Unit Director or designee ensures that referred personnel on active orders are scheduled for evaluation within 30 days after being contacted by the referring base. (T-1)

A3.1.9. Reserve Medical Unit**.** Contacts the epidemiology lab to confirm positive test results before release of information, conducting counseling, or determining need for spousal or contact notification. (T-1)

A3.2. Preventive Health Assessment (PHA): Primary Care Manager ensures HIV testing is accomplished per the clinical testing requirements in the PHA for AD members or ARC members. (T-1)

A3.3. Sexually Transmitted Infection (STI) Clinic Testing:

A3.3.1. Providers counsel all STI patients regarding the need for HIV testing. Immediate HIV testing and follow-up testing IAW the most recent CDC recommendations. Informed consent laws are followed for dependents and civilians. (T-1)

A3.3.2. Providers refer all STI patients to PH for case contact interviews as soon as identified. (T-1)

A3.3.3. Test specimens IAW **A3.1.2** (T-1)

A3.3.4. MTF/CC or designee ensures all HIV positive individuals are properly notified and counseled, and all ADAF members are referred to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. RMU/CC or designee ensures all HIV positive Reservists are properly notified and counseled, and all Reservists eligible for evaluation at the HIV Medical Evaluation Unit at SAMMC for medical evaluation are referred to the Unit for evaluation. (T-1)

A3.4. Drug and/or Alcohol Treatment Testing:

A3.4.1. The Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program Manager or designee notifies all AD members entering treatment programs of required HIV testing and provides the member with AF Form 3844. Local and state laws dictate availability of testing for family members and use of informed consent. Their testing is not mandatory. Individuals who are not DoD military health care beneficiaries (for example, civilian employees) are not HIV tested. (T-1)

A3.4.2. The treatment entrant reports to the MTF laboratory with AF Form 3844.

A3.4.3. Laboratory personnel obtain an HIV specimen and complete Part 2 of AF Form 3844.

A3.4.4. Accomplish the HIV testing IAW **A3.1.2** (T-1)

A3.4.5. The clinical laboratory manager forwards the completed AF Form 3844 to the ADAPT Program Manager or designee who ensures all AD members entering treatment have been HIV tested.

A3.4.6. MTF/CC or designee ensures all HIV positive individuals are properly notified and counseled, and all AD members are referred to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. (T-1)

A3.5. Clinical Testing:

A3.5.1. All health care providers order HIV testing for those patients with clinical indications of HIV related diseases (e.g. active tuberculosis, incident HBV and HCV cases) and for patients with potential exposure to the virus. A confirmed positive result on a urinalysis drug test is a clinical indication for HIV testing. Providers inform patients of HIV testing for clinical indications. Local state informed consent laws are followed for family members and other beneficiaries (for example, retirees). Informed consent is not required for AD members. (T-0)

A3.5.2. Providers ordering HIV testing ensure test results are reviewed, HIV positive patients are counseled, and HIV positive AD members are referred to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. Normally, the HIV designated physician in conjunction with public health personnel, provide counseling and referral services. (T-1)

A3.5.3. Providers will not routinely order HIV testing on all patients. (T-1)

A3.5.4. Clinical testing is accomplished IAW **A3.1.2** (T-1)

A3.6. Occupational Exposure Testing.

A3.6.1. Employees report to PH for occupational exposure testing and follow up IAW OSHA Blood-borne Pathogen Final Rule as implemented in the facility Infection Control Program/Employee Health Program. (T-0)

A3.6.2. Follow the latest CDC guidelines for blood and body fluid exposures to bloodborne pathogens as stated in the facility Infection Control Program/ Employee Health Program/Bloodborne Pathogen Program. Refer to AFI 44-108, *Infection Control Program*. (T-0)

A3.6.3. Personnel who perform exposure-prone procedures (to include, but not limited to, surgeons, pathologists, dentists, dental technicians, phlebotomists, emergency medical technicians, and physicians, nurses and technicians working in the emergency room, intensive care, surgery, and labor/ delivery) should know their HIV antibody status.

A3.6.4. Follow local state laws on HIV testing and informed consent for non-active duty individuals, including employees and patients. Informed consent is not required for active duty personnel. (T-0)

A3.6.5. Personnel testing is accomplished IAW **A3.1.2** (T-1)

A3.7. Prenatal Testing:

A3.7.1. Screen all AD obstetrics (OB) patients for evidence of HIV infection regardless of previous testing. (T-1)

A3.7.2. Encourage nonactive duty OB patients to be tested. Follow local state laws on informed consent for nonactive duty patients.

A3.7.3. Submit additional specimens as clinical specimens, not as OB specimens.

A3.7.4. Accomplish testing IAW **A4.1.2** (T-1)

A3.8. Results Reporting:

A3.8.1. Active Duty. The USAFSAM HIV Testing Services reports negative test results usually electronically to the submitting MTF within three workdays. First time positive notification letters are sent via FedEx Priority Overnight or by encrypted e-mail to the MTF/CC and base PH. Enclosed in each notification letter is an AF Form 74. The MTF/CC and PH officer write on their respective cards the date results were received, complete blocks (phone number, date and sign/organization/installation), document notification of the patient, and return to USAFSAM HIV Testing Services either by mail or by encrypted e-mail. Once the signed AF Form 74 is returned to the USAFSAM HIV Testing Service, the result will be certified in CHCS. Known positive patient's results are made available within 7 working days. (T-1)

A3.8.2. Air National Guard and Air Force Reserve. USAFSAM HIV Testing Services results for Air National Guard and Air Force Reserve units are reported the same as for Active Duty except that units not attached to an MTF with CHCS lab interoperability must log into the Wright-Patterson CHCS platform remotely to retrieve their results. (T-1)

A3.8.3. Clinical and Civilian Employee Samples. The USAFSAM HIV Testing Services report negative test results to the submitting MTF Laboratory Services within 3 working days. If positive, a notification letter is sent via FedEx Priority Overnight within seven workdays to PH. The letter has an AF Form 74 enclosed. The PH officer will write on AF Form 74 the date results were received, complete blocks (phone number, date and sign/organization/installation), document notification of the patient, and return to USAFSAM HIV Testing Services. (T-1)

A3.8.4. Results of HIV Testing Performed at DoD Labs Other Than Air Force**.** Occasionally, HIV testing will be done at Army or Navy laboratories on active duty Air Force personnel. When USAFSAM HIV Testing Services obtain first time positive results from other services, notification on AF members, USAFSAM HIV Testing Service will contact the submitting MTF's PH to ensure that notification has been performed. If notification has not been accomplished, USAFSAM HIV Testing Service will initiate notification as outlined in **A3.9.1**. (T-1)

A3.9. Blood Bank Testing. If a military member is identified as HIV positive through blood donation or other blood bank or outside laboratory testing, a specimen must be sent to USAFSAM HIV Testing Services for confirmation. (T-1)

A3.9.1. All military members with a positive HIV screening test should be referred to public health for appropriate counseling and follow-up instructions regarding further testing. (T-0)

A3.10. Problem Resolution:

A3.10.1. Inform USAFSAM HIV Testing Services of difficulties obtaining supplies or test results.

A3.10.2. The USAFSAM HIV Testing Services handles all test inquiries.

NOTE: Assess HIV risk at every preventive health assessment (PHA) and screen for serologic evidence of HIV infection during their PHA as required (minimum testing every 2 years). ARC personnel are screened during their periodic long flying physical every three years or nonflying physical every five years or as per the PHA clinical testing requirements. DoD mandated testing continues to include sexually transmitted disease (STI) clinic patients, drug and alcohol treatment entrants, prior to PCS OS assignments, prenatal patients, and host country requirements before deployment. (T-1)

Attachment 4

COMPLETION OF FORMS FOR REQUESTING HIV TESTING AND SPECIMEN TRANSMITTAL

A4.1. Composite Healthcare System.

A4.1.1. Submitting labs with Composite Healthcare System (CHCS) have the capability to create and send a list of specimens which can be sent to the receiving lab.

A4.1.1.1. Create a shipping/transmittal list in Composite Healthcare System (CHCS).

A4.1.1.2. Include a copy of the shipping/transmittal list in each specimen package sent to the receiving lab.

A4.1.1.3. Send the shipping/transmittal list electronically (if applicable) to the receiving lab through CHCS.

A4.2. AF FORM 1762 Completion (to be used ONLY by sites without CHCS access):

A4.2.1. AF Form 1762 is used to request HIV Screen Testing when CHCS is not available. The following information is mandatory: the facility/organization and address at the top of each form submitted. If not, specimens will be processed as NBI (no base identification) which will delay results until submitting activity can be ascertained. (T-1)

A4.2.2. For each request**,** the Full Name (last name, first name, middle initial) not nick-names, Full SSN (not last 4) with an FMP, Date of Birth (dates are to be entered as DD-MMM-YY, e.g., October 19, 1948 = 19 Oct 48), Duty Code (see **A5.3**) and Source Code (see **A5.4**). [Force Testing no longer exists. All periodic testing is done in conjunction with **"**P" (physicals) unless meeting one of the other source codes. See **A5.4** Source Codes.] (T-1)

A4.2.3. Testing will not proceed until all information is provided. Additionally, the individual being tested will not receive a test date in the master AFPC records if the name, FMP/SSN, or date of birth, do not match. (T-1)

A4.2.4. Fill out forms LEGIBLY. If entered by hand, the individual responsible for verifying the identity of personnel being screened, not the person being drawn, will print the information. Typewritten or computer generated forms are preferred. If you have computer support, call USAFSAM HIV Testing Services for available software programs to help produce a computer generated AF Form 1762. The AF Form 1762 is available through e-Publishing (**http://www.e-publishing.af.mil/shared/media/epubs/af1762.xfd**).

A4.2.5. At the bottom of the form, fill in date shipped, name of shipping person, or someone USAFSAM HIV Testing Services can contact if there are problems, and a DSN phone number or commercial number only if DSN is unavailable.

A4.2.6. MTF's that use the Composite Healthcare System (CHCS), refer to ADHOC A98 1011, Automated HIV Shipping Form, which can be downloaded from the Brooks web site: **http://www.tmssc.brooks.af.mil**.

A4.2.7. Guard and Reserve bases not utilizing CHCS can use developed software from US AFI HIV Testing Service (phone number DSN 240-8934). Guard and Reserve sites that access the Wright-Patterson CHCS remotely will use the CHCS ad hoc "ASL" (USAFSAM (Epi) Lab Referral Shipping List) function to generate their shipping list(s). This ad hoc

function is given to all Guard and Reserve users who request CHCS access through the Epidemiology Laboratory Information Systems Department.

A4.2.8. Common Errors in filing out AF Form 1762:

A4.2.8.1. Not putting Base ID/Submitting Activity at the top of each form

A4.2.8.2. Name - incomplete or not legible. Has name recently changed or is there a suffix (e.g. "Jr." or "III") after the name?

A4.2.8.3. SSN - more or less than 9 digits; not legible. Failure to include FMP with SSN.

A4.2.8.4. No Duty Code, no Source Code, or entry of unauthorized code.

A4.2.8.5. No Date or Shipping official to contact in case of problems.

A4.2.8.6. No DSN phone or commercial number if DSN unavailable.

A4.2.8.7. Failure to retain copy of AF Form 1762. A4.2.9. Forward the first two copies of the AF Form 1762 to USAFSAM HIV Testing Services along with the specimens. Keep the third copy in the laboratory for MTF record keeping purposes to track timely return of results. If test results have not been received within three days, contact USAFSAM HIV Testing Services for assistance.

A4.2.8.8. The MTF/CC reviews the reports and provides copies of positive results to the physician designated to advise and counsel HIV antibody positive individuals. (T-1)

A4.2.8.9. DoD laboratories authorized to perform HIV antibody clinical screening in-house use AF Form 1762 as a log for all HIV antibody ELISA screenings performed. All five items of information are to be completed. By the fifth working day of the month, forward all results from the previous month electronically or by floppy disc to USAFSAM HIV Testing Services. Forward specimens tested negative to USAFSAM HIV Testing Services marked “DoDSR” for placement in the DoDSR. Forward a specimen from each individual who screens positive for HIV in local testing to USAFSAM HIV Testing Services for confirmatory testing. (T-1)

A4.3. AF Form 4 is used only to request Western Blot Confirmation Testing. Do not use this form for HIV screening requests; use an AF Form 1762 as required in section **A5.1.1** For bases who perform local clinical testing and MTF Blood Banks that screen donors, all specimens that screen positive must be sent to the HIV Testing Services for FDA confirmation algorithm testing. Complete the form as follows: Fill out the top of the form with **all** required information. Blocks 13 and 14 must be completed with Duty Code and Source Code or testing will delayed until information is obtained.

A4.4. Duty Codes: To obtain the most accurate information possible, submitting laboratories must use the patient category code (pat cat code) from CHCS for duty codes on the AF Form 1762 to identify the status of the individual being tested. This is an Alpha, two numeric code which is a mandatory field when registering members into CHCS. Therefore, this information should be available to download to an ADHOC report when computer generating the CHCS AF Form 1762. These codes closely emulate the DEERS codes for status of individual member being tested. For submitting activities not on CHCS, use the Pat Cat that closely defines the status of the individual. The following are the most commonly used:

PAT CATs DEFINITION.

A11 Army, Active Duty A12 Army, Reserve A13 Army, Recruits A14 Army, Academy Cadet A15 Army, National Guard

PAT CATs DEFINITION.

A21 Army, ROTC A23 Army National Guard A26 Army, Applicants-Enlistment's A31 Army, Retired A41 Army, Dependent of Active Duty A43 Army, Dependent of Retiree A45 Army, Dependent of Deceased Active Duty A47 Army, Dependent of Deceased Retiree A48 Army, Unmarried former Spouse

F11 Air Force, Active Duty F12 Air Force, Reserve F13 Air Force, Recruits F14 Air Force, Academy Cadet F15 Air Force, National Guard F21 Air Force, ROTC F23 Air Force National Guard F26 Air Force, Applicants-Enlistment's F31 Air Force, Retired F41 Air Force, Dependent of Active Duty F43 Air Force, Dependent of Retiree F45 Air Force, Dependent of Deceased Active Duty F47 Air Force, Dependent of Deceased Retiree F48 Air Force, Unmarried former Spouse M11 Marine Corps, Active Duty M12 Marine Corps, Reserve M13 Marine Corps, Recruits M14 Marine Corps, Academy-midshipmen M21 Marine Corps, ROTC M26 Marine Corps, Applicants-Enlistment's M31 Marine Corps, Retired M41 Marine Corps, Dependent of Active Duty M43 Marine Corps, Dependent of Retiree M45 Marine Corps, Dependent of Deceased Active Duty M47 Marine Corps, Dependent of Deceased Retiree M48 Marine Corps, Unmarried former Spouse

N11 Navy, Active Duty N12 Navy, Reserve N13 Navy, Recruits N14 Navy, Academy-Midshipmen N21 Navy, ROTC N26 Navy, Applicants-Enlistment's N31 Navy, Retired N41 Navy, Dependent of Active Duty N43 Navy, Dependent of Retiree N45 Navy, Dependent of Deceased Active Duty N47 Navy, Dependent of Deceased Retiree N48 Navy, Unmarried former Spouse

C11 Coast Guard, Active Duty C12 Coast Guard, Reserve

PAT CATs DEFINITION

C31 Coast Guard, Retired C41 Coast Guard, Dependent of Active Duty C43 Coast Guard, Dependent of Retiree

P11 Public Health Svs, Active Duty P12 Public Health Svs, Reserve P31 Public Health Svs, Retired P41 Public Health Svs, Dependent of Active Duty P43 Public Health Svs, Dependent of Retiree

K53 Civil Service Employee/Other Federal Agencies K57 Civilian Employee, Occupational

Health K59 Federal Government Employees, Overseas K61 VA Sharing Agreement/VA beneficiary K64 Other Federal Agency (DAF employee) K66 Federal Prisoners

Table A4.1. PAT CATs Definition.

A11	Army, Active Duty
A12	Army, Reserve
A13	Army, Recruits
A14	Army, Academy Cadet
A15	Army, National Guard
A21	Army, ROTC
A23	Army National Guard
A26	Army, Applicants-Enlistment's
A31	Army, Retired
A41	Army, Dependent of Active Duty
A43	Army, Dependent of Retiree
A45	Army, Dependent of Deceased Active Duty
A47	Army, Dependent of Deceased Retiree
A48	Army, Unmarried former Spouse

F11	Air Force, Active Duty
F12	Air Force, Reserve
F13	Air Force, Recruits
F14	Air Force, Academy Cadet
F15	Air Force, National Guard
F21	Air Force, ROTC
F23	Air Force National Guard
F26	Air Force, Applicants-Enlistment's
F31	Air Force, Retired
F41	Air Force, Dependent of Active Duty
F43	Air Force, Dependent of Retiree
F45	Air Force, Dependent of Deceased Active Duty
F47	Air Force, Dependent of Deceased Retiree
F48	Air Force, Unmarried former Spouse

M11	Marine Corps, Active Duty
M12	Marine Corps, Reserve
M13	Marine Corps, Recruits
M14	Marine Corps, Academy -midshipmen
M15	Marine Corps, National Guard
M21	Marine Corps, ROTC
M23	Marine Corps National Guard
M26	Marine Corps, Applicants-Enlistment's
M31	Marine Corps, Retired
M41	Marine Corps, Dependent of Active Duty
M43	Marine Corps, Dependent of Retiree
M45	Marine Corps, Dependent of Deceased Active Duty
M47	Marine Corps, Dependent of Deceased Retiree
M48	Marine Corps, Unmarried former Spouse

N11	Navy, Active Duty
N12	Navy, Reserve
N13	Navy, Recruits
N14	Navy, Academy Cadet
N15	Navy, National Guard
N21	Navy, ROTC
N23	Navy National Guard
N26	Navy, Applicants-Enlistment's
N31	Navy, Retired
N41	Navy, Dependent of Active Duty
N43	Navy, Dependent of Retiree
N45	Navy, Dependent of Deceased Active Duty
N47	Navy, Dependent of Deceased Retiree
N48	Navy, Unmarried former Spouse
K53	Civil Service Employee/Other Federal Agencies
K57	Civilian Employee, Occupational Health
K59	Federal Government Employees, Overseas
K61	VA Sharing Agreement/VA beneficiary
K64	Other Federal Agency (DAF employee)
K66	Federal Prisoners

C11	Coast Guard, Active Duty
C12	Coast Guard, Reserve
C31	Coast Guard, Retired
C41	Coast Guard, Dependent of Active Duty
C43	Coast Guard, Dependent of Retiree

P11	Public Health Svs, Active Duty
P12	Public Health Svs, Reserve
P31	Public Health Svs, Retired

P41	Public Health Svs, Dependent of Active Duty
P43	Public Health Svs, Dependent of Retiree

A4.5. Source Code. The only authorized codes used in the appropriate block on the AF Form 1762 are listed below. These codes identify the reason that the individual is being screened. They were adopted for use throughout DoD by the Reportable Disease Data Base (RDDB) Working Group. A single code is entered on the AF Form 1762. Multiple codes for an individual are not authorized:

Table A4.2. Source Codes.

A	Alcohol and Drug Treatment
B	Blood Donor (Authorized for use on specimens or confirmation specimens)
C	Contact Testing (Referral)
F	Force Screening (routine screening of personnel)
I	Indicated for Clinical Reasons
J	Prisoners or Detained Persons
M	Medical Admissions (Including Psychiatric)
N	Pre-deployment
O	OB Clinic/Pregnancy Related
P	Physical Examinations
R	Requested by Individual
S	Surgical Admission (Including Invasive Procedures and ER)
T	Post-deployment
V	STI Clinic Visit
X	Any Other Source (used only in extremely rare cases)

A4.6. Shipment of Specimen Requirements.

A4.6.1. Ship specimens using instructions provided by USAFSAM HIV Testing Services. It is very important that the MTFs follow these instructions. Deviation could cause rejection of a shipment and necessitate redrawing each individual.

A4.6.2. USAFSAM HIV Testing Services will only accept 12x75 mm polypropylene tubes. If the whole shipment arrives in anything other than these type tubes, the shipment will be returned to the submitting MTF at their expense to process in the correct tubes. Single specimens will have to be redrawn. Tubes and caps can be ordered from most laboratory supply catalogues (see below) or can be obtained by completing a supply order form and submitting to our Customer Service Team via email at **usafsam.phe.cst@wpafb.af.mil.** This order form can be found on our website at **https://kx.afms.mil/epi.calling** the Epidemiology Laboratory Services at DSN 240-8751 or 8378. If the submitting MTF's stock runs out, it will have to hold specimens until a supply of the correct tubes are received.

Test Tubes, 12x75 mm, polypropylene, round bottom

FSN 6640-01-264-2362

Curtin-Matheseon Scientific (CMS) #289-657

S/P-Baxter T-1226-12

Plug Cap for 12x75 test tubes

FSN 6640-01-2222963

CMS #148-346

S/P-Baxter T1226-32

Tubes and caps in one order

S/P-Baxter T1226-42

Double sided Plastic Bags

Fisher Cat #01-824 Lab Safety Supply Cat #TL-23805

VWR Cat #11216-783

A4.6.3. Label tubes with a CHCS generated label. If CHCS is unavailable, write FULL NAME **(**Last name, first name, middle initial), and the FULL SSN with FMP, and collection date on label, then place label long-wise without covering the bottom of tube. (Pre/Post deployment specimens need draw date). Secure with a plastic plug cap. DO NOT USE PARAFILM.

A4.6.4. Place patient samples in a foam tube rack in the order listed on the shipping/transmittal list or AF Form 1762. Wrap foam tube rack containing specimens in absorbent material and place in a large plastic shipping bag. Place patient samples (amount for 1 AF Form 1762/no more than 22) with absorbent material in large portion of plastic shipping bag. Place one copy of the shipping/transmittal list or one copy and original of AF Form 1762. Place original and one copy of AF Form 1762 inside the outer pouch of the shipping bag corresponding to samples and tear off plastic strip covering the adhesive and to SEAL THE BAG. If foam tube racks are not available, place no more than 10 specimens in a small plastic shipping bag containing absorbent material. Place one copy of the shipping/transmittal list or one copy and original of AF Form 1762 in the outer pouch of the shipping bag and SEAL THE BAG. Repeat for each batch of 10 specimens. In shipping

HIVs specimens with other EPI specimens, place HIV specimens in a separate ziplock plastic shipping bag marked: "HIV"

A4.6.5. The following common errors could be avoided if a quality control program exists.

A4.6.6. Common errors in Specimen Preparation:

A4.6.6.1. Not spinning specimen down causing hemolyzed specimens

A4.6.6.2. Putting specimens in the wrong tubes; only polypropylene 12x75 mm will be accepted.

A4.6.6.3. Over-filling tubes, causing tube cap to come off when the specimen is frozen.

A4.6.6.4. Not putting tube caps on tightly.

A4.6.6.5. Tape or parafilm around the cap of the tube.

A4.6.6.6. Omitting the individual's full name/full SSN on tube

A4.6.6.7. Only last four of SSN on the transport tube.

A4.6.6.8. Name on tube does not match name on shipping/paperwork transmittal list or AF Form 1762.

A4.6.6.9. No shipping/transmittal list or AF Form 1762 accompanying the specimen tube.

A4.6.7. Common Errors in Specimen Packaging:

A4.6.7.1. Not wrapping tubes with absorbent paper material.

A4.6.7.2. Not maintaining a cold environment (use ice, cold packs, or dry ice as appropriate).

A4.6.7.3. Not separating shipping/transmittal lists or AF Forms 1762 from specimens, causing forms to get wet if leakage occurs.

A4.6.7.4. Not sealing the shipping bag completely causing specimens to be lost in transit.

A4.6.7.5. Not packing specimens in foam shipping rack or separating them into batches of ten.

Attachment 5

HIV TESTING AND INTERPRETATION OF RESULTS

A5.1. Laboratories:

A5.1.1. Use only approved MTF laboratories or the USAFSAM HIV Testing Services to perform the initial screening test on specimens collected from Service members. (T-1)

A5.1.2. All approved Air Force MTF laboratories that perform in-house HIV testing must send a serum sample for testing to USAFSAM HIV Testing Services IAW **A3.1.2** This sample will be forwarded to the DoD serum repository after testing by the USAF HIV Testing Service. (T-1)

A5.1.3. The USAFSAM HIV Testing Services, USAFSAM, Wright-Patterson Air Force Base, maintains specimens for seven days after testing then discarded. Specimens from Reserve and Guard units are sent to the DoD serum repository. (T-1)

A5.2. Specimen Collection and Handling:

A5.2.1. Collect blood samples with appropriate vacutainer tubes.

A5.2.2. Label tubes with a CHCS generated label. As a minimum, each sample is labeled with three unique patient identifiers such as; the individual's full name, FMP/SSN, date of birth or a laboratory assigned number. Also include the date and time of collection.

A5.2.3. Samples are centrifuged and serum separated within six hours of collection.

A5.2.4. Specimens should be refrigerated before the initial test. If the initial test is cannot be conducted within seven days, or the date at which the sample was collected is unknown, the specimen must be frozen (≤ -20°C).

A5.2.5. Use cold packs to keep specimens at refrigerated temperatures (2 – 8°C) or shipped on dry ice if the samples are frozen (≤ -20°C) during transit between laboratories.

A5.2.6. Ship specimens according to US (or foreign) biological agent shipping requirements.

A5.3. Initial Test:

A5.3.1. Conduct the initial test using a FDA-approved screening test. Interpret results according to the manufacturer's package insert.

A5.3.2. The laboratory establishes an internal quality control program.

A5.3.3. All controls will be 100 percent correct before the entire batch results are considered acceptable.

A5.4. Supplemental/Confirmatory Tests:

A5.4.1. All HIV testing will follow an APHL/CDC-approved algorithm. (T-0)

A5.4.2. Perform a FDA-approved confirmatory test, such as a Western Blot (WB) test. For Western Blot tests with indeterminate results, an alternative FDA approved test can be used to resolve indeterminates such as a viral load-based assay (APTIMA) or other FDA approved testing platform. (T-0)

A5.4.3. The laboratory validates its procedure using a protocol that establishes accuracy, precision, and reproducibility.

Attachment 6

HIV TESTING OF DOD CIVILIAN EMPLOYEES

A6.1. Direct requests for authority to screen DoD civilian employees for HIV to the Assistant Secretary of Defense (ASD)/Force Management and Personnel (FM&P). Only requests that are based on a host nation HIV screening requirement are accepted. Requests based on other concerns, such as sensitive foreign policy or medical health care issues, are not considered under this instruction. Approvals are provided in writing by the ASD/FM&P and apply to all the DoD Components that may have activities located in the host nation. (T-0)

A6.2. Specific HIV screening requirements may apply to DoD civilian employees currently assigned to positions in the host nation and to prospective employees. When applied to prospective employees, HIV screening is considered a requirement imposed by another nation, that must be met before the final decision to select the individual for a position, or before approving temporary duty or detail to the host nation. Individuals who refuse to cooperate with HIV screening requirements or those who cooperate and are diagnosed as HIV seropositive, may not be considered further for employment in host nations with HIV screening requirements. (T-0)

A6.3. DoD civilian employees who refuse to cooperate with the screening requirements are treated, as follows:

A6.3.1. Those who volunteered for the assignment, whether permanent or temporary, are retained in their official position without further action and without prejudice to employee benefits, career progression opportunities, or other personnel actions to which those employees are entitled under applicable law or instruction.

A6.3.2. Those who are obligated to accept assignment to the host nation under the terms of an employment agreement, regularly scheduled tour of duty, or similar and/or prior obligation may be subjected to an appropriate adverse personnel action under the specific terms of the employment agreement or other authorities that may apply.

A6.3.3. Host nation screening requirements, which apply to DoD civilian employees currently located in that country, must be observed. Appropriate personnel actions may be taken, without prejudice to employee rights and privileges to comply with the requirements. (T-0)

A6.4. Individuals who are not employed in the host nation, who accept the screening, and who are evaluated as HIV seropositive shall be denied the assignment on the basis that evidence of seronegativity is required by the host nation. If denied the assignment, such DoD employees shall be retained in their current positions without prejudice. Appropriate personnel actions may be taken, without prejudice to employee rights and privileges, on DoD civilian employees currently located in the host nation. In all cases, employees shall be given proper counseling and shall retain all the rights and benefits to which they are entitled, including accommodations for the handicapped as in the applicable ASD/FM&P Memorandum, and for employees in the United States (29 U.S.C. 794). Non-DoD employees are referred to appropriate support service organizations. (T-0)

A6.5. Some host nations may not bar entry to HIV seropositive DoD civilian employees, but may require reporting of such individuals to host nation authorities. In such cases, DoD civilian employees who are evaluated as HIV seropositive shall be informed of the reporting

requirements. They shall be counseled and given the option of declining the assignment and retaining their official positions without prejudice or notification to the host nation. If assignment is accepted, the requesting authority shall release the HIV seropositive result, as required. Employees currently located in the host nation may also decline to have seropositive results released. In such cases, they may request and shall be granted early return at government expense or other appropriate personnel action without prejudice to employee rights and privileges. (T-0)

A6.6. A positive HIV screening test must be confirmed by an FDA approved confirmatory test according to an APHL/CDC approved algorithm. A civilian employee may not be identified as HIV antibody positive, unless the confirmatory test is positive. The clinical standards in this instruction shall be observed during initial and confirmatory testing. (T-0)

A6.7. Provide tests at no cost to the DoD civilian employees, including applicants. (T-0)

A6.8. Counsel DoD civilian employees infected with HIV. (T-0)

Attachment 7

GUIDELINES FOR ADMINISTERING THE ORDER TO FOLLOW PREVENTIVE MEDICINE REQUIREMENTS TO INDIVIDUALS INFECTED WITH HIV

A7.1. After the member is notified by a health care provider that he or she has tested positive for HIV infection, and the significance of such a test, the MTF/CC expeditiously notifies the member's unit commander of the positive test results. For active duty members, the member's unit commander issues an order to follow preventive medicine requirements. For unit assigned reservists, this order is issued only after their immediate commander determines the member will be retained in the Selected Reserve. When the order is given, a credentialed provider is present to answer any medical concerns of the member. Use the order at **Attachment 13**. It is signed and dated by the commander and member. If the member refuses to sign, the commander notes that the member refused to sign in the acknowledgment section. The order is securely stored to protect the member's privacy and confidentiality. A copy of the order is provided to the member. Upon the individual's reassignment, the unit commander forwards the order in a sealed envelope to the gaining commander. The envelope is marked "To Be Opened By Addressee Only." Upon the individual's separation from the Air Force, the order is destroyed. (T-1)

A7.2. AD members testing positive for HIV infection undergo a complete medical evaluation at SAMMC. Upon arrival, all HIV positive members are counseled by a health care provider or by the HIV Community Health Nurse (CHN) assigned to the HIV Medical Evaluation Unit at SAMMC. Use AF Form 3845, **Preventive Medicine Counseling Record,** or similar form. The CHN signs the form. The member signs the counseling record acknowledging receipt of the counseling. One copy of the record is given the member and one copy filed in the records of the HIV CHN. (T-1)

A7.3. If the member is returned to duty from the HIV Medical Evaluation Unit to a different unit from which he or she came, the gaining unit commander issues an additional order to follow preventive medicine requirements to the member. A copy of this order is given to the member. Use the order at **Attachment 13**. The commander may request the MTF/CC or other health care provider is present when the order is administered to answer any medical concerns of the member. The commander and member sign and date the order. If the member refuses to sign, the commander notes the member refused to sign in the acknowledgment section. Securely store the order to protect the member's privacy and confidentiality. (T-1)

A7.4. It is unnecessary to recall members issued orders under former procedures. HIV seropositive members, who have not been previously issued preventive medicine requirement orders, must be counseled by a health care provider assigned to the local medical facility on AF Form 3845 and issued an order (**Attachment 13**) by his or her unit commander. (T-1)

NOTE: DoD requested the Military Departments standardize the administration of the order to follow preventive medicine requirements to individuals infected with HIV. The guidelines above standardize and simplify procedures.

Attachment 8

STANDARD CLINICAL PROTOCOL

A8.1. Medical Evaluation:

A8.1.1. Accomplish a complete medical evaluation of AF personnel with HIV infection with an initial visit, a second visit at 6 months, and subsequent visits every 12 months at SAMMC as long as the member is retained on active duty. HIV disease will be staged according to current CDC guidelines for every clinical visit. Interim medical visits will be performed as necessary in the member's local area in accordance with current DHHS Guidelines for Management of Adult HIV Infections. For unit assigned reservists not on extended active duty, this evaluation is not accomplished until after the commander's decision to retain the member. If the member is retained, the evaluation must be accomplished and documented IAW AFI 48-123, AFI 41-210, and AFRC medical guidance on nonduty related medical conditions. (T-1)

A8.1.2. Maintain a frozen serum specimen on all HIV positive individuals at a central serum bank for at least three years at -70 degrees Celsius. (T-1)

A8.1.3. Seek psychiatric consultation if there are concerns about fitness for duty or if the screening evaluation suggests more detailed psychiatric evaluation is needed. If the patient has persistent evidence of diminished intellectual skills, personality changes, and motor impairment, more specialized studies (neurologic studies, computed tomography or magnetic resonance imaging, lumbar puncture, psychiatric examination, and neuropsychiatric testing) may be required to evaluate the possible presence of a HIV-related mental or neurological syndrome. (T-1)

A8.1.4. Perform additional testing in both initial and follow-up epidemiologic/clinical assessments as indicated to maintain compliance with changes in accepted standards of care for management of HIV infection. (T-1)

A8.2. Medical Record Coding of HIV-1 Infections. Follow current ICD CM coding guidelines for medical record coding of HIV infection.

A8.3. Disposition of Members Infected:

A8.3.1. DoD Directive 1332.18, Separation From the Military Service by Reason of Physical Disability, November 4, 1996, and AFI 41-210, Medical Evaluations Boards (MEB) and Continued Military Service, provides guidelines for fitness for duty determinations. However, MEB pre-screening will occur with an Initial Review in Lieu of an MEB (I-RILO) under the guidelines of AFI 41-210, chapter 4, section 4k. This guidance provides I-RILO screening procedures for both ADAF members Air Reserve Component members. (T-0)

A8.3.2. Refer AD members infected with HIV for I-RILO in accordance with AFI 41-210, immediately following the initial evaluation. However, while I-RILOs usually require a letter from the member's Commander indicating the impact of a member's condition upon his/her duty performance, such a letter is not required in the case of HIV seropositive members because of the risk of Privacy Act violations while routing such letters through the Commander's support staff. I-RILOs will only be submitted from the HIV Medical

Evaluation Unit at SAMMC and individual home bases are not to submit I-RILOs or annual ALC-C RILOs for HIV infection. (T-1)

Attachment 9

RETENTION AND SEPARATION

A9.1. Retention:

A9.1.1. Members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, may not be separated solely on the basis of laboratory evidence of HIV infection. (T-0)

A9.1.2. HIV-infected members who have been evaluated for continued military service and are retained will receive an Assignment Limitation Code (ALC-C). Please refer to AFI 41-210 for ALC-C stratifications and for a list of waiver authorities for OCONUS TDY and/or assignment. (T-1)

A9.2. Separation:

A9.2.1. AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation,* provides guidance for separation or retirement of AD members who are determined to be unfit for further duty.

A9.2.2. AD and Reserve members with laboratory evidence of HIV infection found not to have complied with lawfully ordered preventive medicine procedures are subject to administrative and disciplinary action, which may include separation.

A9.2.3. Separation of AD members with laboratory evidence of HIV infection under the plenary authority of the Secretary of the Air Force, if requested by the member, is permitted.

A9.2.4. The immediate commander of ARC members not on extended active duty who show serologic evidence of HIV infection will determine if the member can be utilized in the Selected Reserve. If the member cannot be utilized, he/she may be transferred involuntarily to the Standby Reserve or separated. If separated, the characterization of service shall never be less than that warranted by the member's service record. (T-1)

A9.2.5. Air Force members determined to have been infected with HIV at the time of enlistment or appointment are subject to discharge for erroneous enlistment or appointment. (T-1)

Attachment 10

LIMITATIONS ON THE USE OF INFORMATION FROM EPIDEMIOLOGICAL ASSESSMENTS

A10.1. Limitations of Results:

A10.1.1. Laboratory tests results performed under this instruction may not be used as the sole basis for separation of a member. The results may be used to support a separation based on physical disability or as specifically authorized by any section in this instruction. This instruction shall not preclude use of laboratory test results in any other manner consistent with law or instruction. (T-1)

A10.1.2. Laboratory test results confirming evidence of HIV infection may not be used as an independent basis for any adverse administrative action or any disciplinary action, including punitive actions under the Uniform Code of Military Justice (UCMJ) (10 U.S.C. 47, reference [j]). (T-1) However, such results may be used for other purposes including, but not limited to, the following:

A10.1.2.1. Separation under the accession testing program.

A10.1.2.2. Voluntary separation for the convenience of the Government.

A10.1.2.3. Other administrative separation action authorized by Air Force policy.

A10.1.2.4. In conducting authorized Armed Services Blood Program Look Back activities.

A10.1.2.5. Other purposes (such as rebuttal or impeachment) consistent with law or instruction (e.g., the Federal or Military Rules of Evidence or the Rules of Evidence of a State), including to establish the HIV seropositivity of a member when the member disregards the preventive medicine counseling or the preventive medicine order or both in an administrative or disciplinary action based on such disregard or disobedience.

A10.1.3. HIV infection is an element in any permissible administrative or disciplinary action, including any criminal prosecution (e.g., as an element of proof of an offense charged under the UCMJ or under the code of a State or the United States).

A10.1.4. HIV infection is a proper ancillary matter in an administrative or disciplinary action, including any criminal prosecution (e.g., as a matter in aggravation in a court-martial in which the HIV positive member is convicted of an act of rape committed after being informed that he or she is HIV positive).

A10.2. Limitations on the Use of Information Obtained in the Epidemiological Assessment Interview:

A10.2.1. Information obtained from a member during, or as a result of, an epidemiological assessment interview may not be used against the member in the following situations:

A10.2.1.1. A court-martial.

A10.2.1.2. Line of duty determination.

A10.2.1.3. Nonjudicial punishment.

A10.2.1.4. Involuntary separation (other than for medical reasons).

A10.2.1.5. Administrative or punitive reduction-in-grade.

A10.2.1.6. Denial of promotion.

A10.2.1.7. An unfavorable entry in a personnel record.

A10.2.1.8. A denial to reenlistment.

A10.2.1.9. Any other action considered by the Secretary of the Air Force concerned to be an adverse personnel action.

A10.2.2. The limitations in paragraph **A10.2.1** do not apply to the introduction of evidence for appropriate impeachment or rebuttal purposes in any proceeding, such as one in which the evidence of drug abuse or relevant sexual activity (or lack thereof) has been first introduced by the member or to disciplinary or other action based on independently derived evidence.

A10.2.3. The limitations in paragraph **A10.2.1** do not apply to nonadverse personnel actions on a case-by-case basis, such as: A10.2.3.1. Reassignment. A10.2.3.2. Disqualification (temporary or permanent) from a personnel reliability program. A10.2.3.3. Denial, suspension, or revocation of a security clearance. A10.2.3.4. Suspension or termination of access to classified information.

A10.2.4. Removal (temporary or permanent) from flight status or other duties requiring a high degree of stability or alertness, including explosive ordnance disposal or deep-sea diving.

A10.3. Entries in Personnel Records: Except as authorized by this instruction, if any such personnel actions are taken because of, or are supported by, serologic evidence of HIV infection or information described in paragraph **A10.1.2**, no unfavorable entry may be placed in a personnel record for such actions. Recording a personnel action is not an unfavorable entry in a personnel record. Additionally, information reflecting an individual's serologic or other evidence of infection with HIV is not grounds for an unfavorable entry in a personnel record.

Attachment 11

PERSONNEL NOTIFICATION, MEDICAL EVALUATION, AND EPIDEMIOLOGICAL INVESTIGATION

A11.1. Personnel Notification:

A11.1.1. Once a health care authority has been notified of an individual with serologic or other laboratory/clinical evidence of HIV infection, public health and or the HIV designated physician shall undertake preventive medicine intervention. The CHN and physician staff at the SAMMC HIV Medical Evaluation Unit will assist military and civilian blood bank organizations and preventive medicine authorities with blood donor look back tracing and referral and refer case-contact information to the appropriate military or civilian health authority. (T-0)

A11.1.2. All individuals with serologic evidence of HIV infection who are military healthcare beneficiaries shall be counseled by a physician or a designated healthcare provider on the significance of a positive antibody test. They shall be advised as to the mode of transmission, the appropriate precautions and personal hygiene measures required to minimize transmission through sexual activities and/ or intimate contact with blood or blood products, and of the need to advise any past or future sexual partners of their infection. Women shall be advised of the risk of perinatal transmission during past, current, and future pregnancies. The individuals shall be informed that they are ineligible to donate blood, sperm, organs or tissues and shall be placed on a permanent donor deferral list. (T-0)

A11.1.3. Service members identified to be at risk shall be counseled and tested for serologic evidence of HIV infection. Other DoD beneficiaries, such as retirees and family members, identified to be at risk, shall be informed of their risk and offered serologic testing, clinical evaluation, and counseling. The names of individuals identified to be at risk who are not eligible for military healthcare shall be referred to civilian health authorities in the local area where the index case is identified, unless prohibited by the appropriate State or host-nation civilian authority. Anonymity of the HIV index case shall be maintained, unless reporting is required by civil authorities. (T-0)

A11.1.4. Blood donors who demonstrate repeatedly reactive screening tests for HIV, but for whom confirmatory test(s) are negative or indeterminate are not eligible for blood donor pool, shall be appropriately counseled. (T-0)

A11.2. Medical Evaluation:

A11.2.1. Active duty personnel and ARC members on extended active duty who have tested positive for HIV shall be sent to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. All DoD directed evaluations will be completed as an outpatient, coordinated by the HIV Evaluation Unit staff. All Active Duty HIV patients undertaking their initial evaluation will undergo mental health status screening by a SAMMC mental health provider. (T-1)

A11.2.2. Physically or mentally unstable HIV patients should have their conditions addressed and stabilized sufficiently for outpatient management prior to transport. Upon arrival, those patients exhibiting an active process requiring physician attention during non-duty hours will be admitted to the appropriate inpatient service. (T-1)

A11.2.3. SAMMC HIV Medical Evaluation Unit staff will conduct a confidential patient epidemiologic interview, repeat the contact notification process, and verify blood donation "lookback" process. The HIV Evaluation Unit CHN or designee will provide the disease education and risk reduction counseling during the patient interview, and complete two copies of the standardized medical counseling form ("Prevention Medicine Counseling Record"). One copy is given to the patient, and the other copy maintained in the HIV CHN's confidential patient files. If the patient refuses to sign, SAMMC Directorate of Medical Law will be notified. The "Order to Follow Preventive Medicine Requirements" is issued by the unit commander of an HIV infected person prior to the patient's initial evaluation by the HIV unit. (T-1)

A11.2.4. All HIV infected active duty and TDRL personnel arriving at SAMMC will receive medical evaluation and staging of their HIV disease by an assigned HIV unit staff physician. The physician will also provide disease specific patient education and appropriate treatment recommendations, and serve as liaison with consulting or inpatient services when necessary. The HIV unit physician will be available to the patient's primary care provider for ongoing patient management and any issues concerning scheduled reevaluations. (T-1)

A11.3. Epidemiological Investigation:

A11.3.1. Epidemiological investigation shall attempt to determine potential contacts of patients who have serologic or other laboratory or clinical evidence of HIV infection. The patient shall be informed of the importance of case-contact notification to interrupt disease transmission and shall be informed that contacts shall be advised of their potential exposure to HIV. Individuals at risk of infection include sexual contacts (male or female); children born to infected mothers; recipients of blood, blood products, organs, tissues, or sperm; and users of contaminated intravenous drug paraphernalia. At risk individuals who are eligible for healthcare in the military medical system shall be notified. The Secretaries of the Military Departments shall designate all spouses (regardless of the Service affiliation of the HIV infected Reservist) who are notified under this provision to receive serologic testing and counseling on a voluntary basis from MTFs under the Secretaries' of the Military Departments jurisdiction. (T-0)

A11.3.2. Communicable disease reporting procedures shall be followed consistent with this Directive through liaison between the public health authorities and the appropriate local, State, Territorial, Federal, or host-nation health jurisdiction. (T-0)

Attachment 12

PROCEDURE FOR EVALUATING T-HELPER CELL COUNT

A12.1. Analytical Procedure:

A12.1.1. Determine the percentage of CD4+ and CD3+ positive lymphocytes by immunophenotyping blood cells using flow-cytometry instrumentation per applicable CDC guidelines. Each laboratory performing T-helper cell counts maintains a current and complete standard operating procedure manual. The absolute T-helper cell count is a product of the percentage of T-helper cells (defined as CD4+ and CD3+ positive lymphocytes) and the absolute lymphocyte level.

A12.2. Internal Quality Control Program:

A12.2.1. Each laboratory maintains a comprehensive internal quality control program. Minimally, on each day of operation monitor the following flow-cytometry procedures or reagents:

A12.2.1.1. Optical focusing and alignment of all lenses and light paths for forward-angle light scatter, right-angle light scatter, red fluorescence, and green fluorescence if these functions are adjustable on the instrument.

A12.2.1.2. Standardize fluorescent intensity beads, particles, or cells with fluorescence in the range of biological samples.

A12.2.1.3. Verify fluorescent compensation beads, particles, or cells with fluorescence in the range of biological samples.

A12.2.1.4. A human blood control sample or equivalent.

A12.2.2. Each laboratory establishes tolerance limits for each of the procedures or reagents in paragraph **A12.1** Take corrective action and document when any quality control reagent exceeds established tolerance limits. Accomplish routine maintenance and function verification checks. The laboratory director regularly reviews corrective and quality control records.

A12.3. External Quality Control Program: The Army establishes and operates an external quality control program to evaluate the results reported by the flow-cytometry laboratories. The external quality control program includes a hematology survey to monitor the performance of the absolute lymphocyte count and a flow-cytometry survey to monitor the performance of each immunophenotyping procedure.

A12.4. Recording and Reporting Data: The laboratory director reviews and verifies the reported results. The laboratory report contains data from which absolute and relative values may be calculated for each lymphocyte subpopulation along with locally derived normal ranges inclusive of the fifth and ninety-fifth percentiles. The laboratory maintains permanent files of patient reports, internal and external quality control records, and instrument maintenance and performance verification checks.

A12.5. Personnel Qualifications:

A12.5.1. Properly train all personnel involved with the flow-cytometry instrumentation.

A12.5.2. Director of the flow-cytometry laboratory holds a doctoral degree in a biologic science or is a physician and possesses experience in immunology or cell biology.

A12.5.3. Technical supervisor holds a bachelor's degree in a biological science and has at least two years of experience in flow-cytometry.

A12.6. Safety: All laboratories comply with the CDC biosafety level 2 standards. All procedures having the potential to create infectious aerosols shall be conducted within the confines of a Class II biological safety cabinet. Although certain specimen processing procedures may inactivate infectious agents, all material is treated as infectious throughout all procedures. Decontaminate all material generated in the processing and evaluation of blood specimens and dispose of using established hazardous waste disposal policies.

Attachment 13

ORDER TO FOLLOW PREVENTIVE MEDICINE REQUIREMENTS

Because of the necessity to safeguard the overall health, welfare, safety, and reputation of this command and to ensure unit readiness and the ability of the unit to accomplish its mission, certain behavior and unsafe health procedures must be proscribed for members who are diagnosed as positive for HIV infection.

As a military member who has been diagnosed as positive for HIV infection, you are hereby ordered:

(1) to verbally inform sexual partners that you are HIV positive prior to engaging in sexual relations. This order extends to sexual relations with other military members, military dependents, civilian employees of DoD components or any other persons;

(2) to use proper methods to prevent the transfer of body fluids during sexual relations, including the use of condoms providing an adequate barrier for HIV (e.g. latex);

(3) in the event that you require emergency care, to inform personnel responding to your emergency that you are HIV positive as soon as you are physically able to do so.

(4) when seeking medical care, you may wish to inform the provider that you have HIV so that the provider can use that information to optimize your evaluation and treatment;

(5) not to donate blood, sperm, tissues, or other organs.

Violating the terms of this order may result in adverse administrative action or punishment under the Uniform Code of Military Justice for violation of a lawful order.

_____

Signature of Commander and Date

ACKNOWLEDGMENT

I have read and understand the terms of this order and acknowledge that I have a duty to obey this order. I understand that I must inform sexual partners, including other military members, military dependents, civilian employees of DoD components, or any other persons, that I am HIV positive prior to sexual relations; that I must use proper methods to prevent the transfer of body fluids while engaging in sexual relations, including the use of condoms providing an adequate barrier for HIV; that if I need emergency care I will inform personnel responding to my emergency that I am HIV positive as soon as I am physically able to do so; that when I seek medical or dental care I may wish to inform the provider that I have HIV in order to optimize my evaluation and treatment; and that I must not donate blood, sperm, tissues, or other organs. I understand that violations of this order may result in adverse administrative actions or punishment under the Uniform Code of Military Justice for violation of a lawful order.

_____

Signature of Member and Date

CIVIL COVER SHEET

JS-44 (Rev. 6/17 DC)

I. (a) PLAINTIFFS

JOHN VOE

(b) COUNTY OF RESIDENCE OF FIRST LISTED PLAINTIFF _____
(EXCEPT IN U.S. PLAINTIFF CASES)

DEFENDANTS

JAMES N. MATTIS, in his official capacity as Secretary of Defense; HEATHER A. WILSON, in her official capacity as Secretary of the Air Force; and the UNITED STATES DEPARTMENT OF DEFENSE.

COUNTY OF RESIDENCE OF FIRST LISTED DEFENDANT _____
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED

(c) ATTORNEYS (FIRM NAME, ADDRESS, AND TELEPHONE NUMBER)

Peter E. Perkowski
OUTSERVE-SLDN, INC.
P.O. Box 65301
Washington, DC 20035-5301
T: 1-800-538-7418

ATTORNEYS (IF KNOWN)

II. BASIS OF JURISDICTION
(PLACE AN x IN ONE BOX ONLY)

- ○ 1 U.S. Government Plaintiff
- ○ 3 Federal Question (U.S. Government Not a Party)
- ◉ 2 U.S. Government Defendant
- ○ 4 Diversity (Indicate Citizenship of Parties in item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (PLACE AN x IN ONE BOX FOR PLAINTIFF AND ONE BOX FOR DEFENDANT) **FOR DIVERSITY CASES ONLY!**

	PTF	DFT		PTF	DFT
Citizen of this State	○ 1	○ 1	Incorporated or Principal Place of Business in This State	○ 4	○ 4
Citizen of Another State	○ 2	○ 2	Incorporated and Principal Place of Business in Another State	○ 5	◉ 5
Citizen or Subject of a Foreign Country	○ 3	○ 3	Foreign Nation	○ 6	○ 6

IV. CASE ASSIGNMENT AND NATURE OF SUIT

(Place an X in one category, A-N, that best represents your Cause of Action and one in a corresponding Nature of Suit)

○ **A. *Antitrust***

- ☐ 410 Antitrust

○ **B. *Personal Injury/ Malpractice***

- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Medical Malpractice
- ☐ 365 Product Liability
- ☐ 367 Health Care/Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Product Liability

○ **C. *Administrative Agency Review***

- ☐ 151 Medicare Act

Social Security
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

Other Statutes
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 890 Other Statutory Actions (If Administrative Agency is Involved)

○ **D. *Temporary Restraining Order/Preliminary Injunction***

Any nature of suit from any category may be selected for this category of case assignment.

(If Antitrust, then A governs)

◉ **E. *General Civil (Other)*** **OR** ○ **F. *Pro Se General Civil***

Real Property
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent, Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

Personal Property
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

Bankruptcy
- ☐ 422 Appeal 27 USC 158
- ☐ 423 Withdrawal 28 USC 157

Prisoner Petitions
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Conditions
- ☐ 560 Civil Detainee – Conditions of Confinement

Property Rights
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent – Abbreviated New Drug Application
- ☐ 840 Trademark

Federal Tax Suits
- ☐ 870 Taxes (US plaintiff or defendant)
- ☐ 871 IRS-Third Party 26 USC 7609

Forfeiture/Penalty
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

Other Statutes
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 430 Banks & Banking
- ☐ 450 Commerce/ICC Rates/etc.
- ☐ 460 Deportation
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions
- ☐ 470 Racketeer Influenced & Corrupt Organization
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Satellite TV
- ☒ 850 Securities/Commodities/ Exchange
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes
- ☐ 890 Other Statutory Actions (if not administrative agency review or Privacy Act)

○ **G. *Habeas Corpus/ 2255*** ☐ 530 Habeas Corpus – General ☐ 510 Motion/Vacate Sentence ☐ 463 Habeas Corpus – Alien Detainee	○ **H. *Employment Discrimination*** ☐ 442 Civil Rights – Employment (criteria: race, gender/sex, national origin, discrimination, disability, age, religion, retaliation) *(If pro se, select this deck)*	○ **I. *FOIA/Privacy Act*** ☐ 895 Freedom of Information Act ☐ 890 Other Statutory Actions (if Privacy Act) *(If pro se, select this deck)*	○ **J. *Student Loan*** ☐ 152 Recovery of Defaulted Student Loan (excluding veterans)
○ **K. *Labor/ERISA (non-employment)*** ☐ 710 Fair Labor Standards Act ☐ 720 Labor/Mgmt. Relations ☐ 740 Labor Railway Act ☐ 751 Family and Medical Leave Act ☐ 790 Other Labor Litigation ☐ 791 Empl. Ret. Inc. Security Act	○ **L. *Other Civil Rights (non-employment)*** ☐ 441 Voting (if not Voting Rights Act) ☐ 443 Housing/Accommodations ☐ 440 Other Civil Rights ☐ 445 Americans w/Disabilities – Employment ☐ 446 Americans w/Disabilities – Other ☐ 448 Education	○ **M. *Contract*** ☐ 110 Insurance ☐ 120 Marine ☐ 130 Miller Act ☐ 140 Negotiable Instrument ☐ 150 Recovery of Overpayment & Enforcement of Judgment ☐ 153 Recovery of Overpayment of Veteran's Benefits ☐ 160 Stockholder's Suits ☐ 190 Other Contracts ☐ 195 Contract Product Liability ☐ 196 Franchise	○ **N. *Three-Judge Court*** ☐ 441 Civil Rights – Voting (if Voting Rights Act)

V. ORIGIN

○ 1 Original Proceeding ○ 2 Removed from State Court ○ 3 Remanded from Appellate Court ○ 4 Reinstated or Reopened ○ 5 Transferred from another district (specify) ○ 6 Multi-district Litigation ○ 7 Appeal to District Judge from Mag. Judge ○ 8 Multi-district Litigation – Direct File

VI. CAUSE OF ACTION (CITE THE U.S. CIVIL STATUTE UNDER WHICH YOU ARE FILING AND WRITE A BRIEF STATEMENT OF CAUSE.)

28 U.S.C. §§ 1331. Suit alleging unconstitutional and improper medical discharge from the United States Air Force.

VII. REQUESTED IN COMPLAINT CHECK IF THIS IS A **CLASS ACTION** UNDER F.R.C.P. 23 **DEMAND $** **JURY DEMAND:** Check YES only if demanded in complaint **YES** ☐ **NO** ☐

VIII. RELATED CASE(S) IF ANY (See instruction) **YES** ☐ **NO** ☒ If yes, please complete related case form

DATE: 5/30/18 **SIGNATURE OF ATTORNEY OF RECORD** _____

INSTRUCTIONS FOR COMPLETING CIVIL COVER SHEET JS-44
Authority for Civil Cover Sheet

The JS-44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and services of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. Listed below are tips for completing the civil cover sheet. These tips coincide with the Roman Numerals on the cover sheet.

I. COUNTY OF RESIDENCE OF FIRST LISTED PLAINTIFF/DEFENDANT (b) County of residence: Use 11001 to indicate plaintiff if resident of Washington, DC, 88888 if plaintiff is resident of United States but not Washington, DC, and 99999 if plaintiff is outside the United States.

III. CITIZENSHIP OF PRINCIPAL PARTIES: This section is completed only if diversity of citizenship was selected as the Basis of Jurisdiction under Section II.

IV. CASE ASSIGNMENT AND NATURE OF SUIT: The assignment of a judge to your case will depend on the category you select that best represents the primary cause of action found in your complaint. You may select only one category. You must also select one corresponding nature of suit found under the category of the case.

VI. CAUSE OF ACTION: Cite the U.S. Civil Statute under which you are filing and write a brief statement of the primary cause.

VIII. RELATED CASE(S), IF ANY: If you indicated that there is a related case, you must complete a related case form, which may be obtained from the Clerk's Office.

Because of the need for accurate and complete information, you should ensure the accuracy of the information provided prior to signing the form.

Dated: May 30, 2018

Respectfully submitted,

/s/ Peter E. Perkowski

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** Application for admission or renewal filed with the clerk of this Court

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

JOHN VOE

Plaintiff(s)

v.

JAMES MATTIS, in his official capacity as Secretary of Defense; HEATHER WILSON, in her official capacity as Secretary of the Air Force; and the United States DEPARTMENT OF DEFENSE.

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* JAMES MATTIS
Secretary of Defense
1000 Defense Pentago, Room 3E880
Washington, D.C. 20301
Telephone: 703-692-7100

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Peter E. Perkowski
PeterP@outserve.org
OUTSERVE-SLDN, INC.
P.O. Box 65301
Washington, DC 20035-5301
T: 1-800-538-7418

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

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