BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 48-123

24 SEPTEMBER 2009

Incorporating Through Change 2, 18 October 2011

AIR FORCE MATERIEL COMMAND Supplement

19 JULY 2012

Aerospace Medicine

MEDICAL EXAMINATIONS AND STANDARDS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available for downloading or ordering on the e-Publishing website at **www.e-publishing.af.mil**.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AF/SG3P

Certified by: AF/SG3 (Maj Gen Thomas J Loftus)

Supersedes: AFI 48-123, Volume 1, 5 Jun 2006; AFI 48-123, Volume 2, 5 Jun 2006; AFI 48-123, Volume 3, 5 Jun 2006; AFI 48-123, Volume 4, 5 Jun 2006

Pages: 196

(AFMC)

OPR: AFMC/SGPA

Certified by: AFMC/SG2 (Col JAMES E. KING)

Supersedes: AFI 48-123_AFMCSUP1_I, 9 Nov 2001, AFI 48-123_AFMCSUP2_I, 2 Jun 2002 Pages: 4

Pages:

This instruction implements Air Force Policy Directive (AFPD) 48-1, *Aerospace Medicine Program* AFPD 36-32, *Military Retirements and Separations* and AFI 36-3212, *Physical Evaluation for Retention, Retirement or Separation* and Department of Defense (DOD) Directive, 1332.18, *Separation or Retirement for Physical Disability*, and DOD Directive 6130.3, *Physical Standards for Appointment, Enlistment and Induction*, DOD Instruction, 6130.4, *Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces)*. 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. This publication does not apply to Air Force Civilian Employees or applicants to the civilian workforce. This publication applies to Air Force Reserve Command (AFRC) Units and Individual Mobilization Augmentee (IMA). This publication applies to the Air Force Pre-trained Individual Manpower (PIM). This publication applies to the Air National Guard (ANG).

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. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records* and disposed of in accordance with the *Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS)* located at **https://www.my.af.mil/gcss-af61a/afrims/afrims**/. The reporting requirement in this instruction is exempt from licensing according to AFI 33-324 paragraph 2.11.10, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*. 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 Form 847s from the field through the appropriate functional's chain of command. **Attachment 1** is a list of references and supporting information.

(AFMC) This supplement expands on the guidance in Air Force Instruction (AFI) 48-123, *Medical Examinations and Standards.* The AFI is published word-for-word without editorial review. This describes AFMCs procedures for use in conjunction with the basic AFI. It applies to all units with Non-rated Aircrew (NRA), US Government Civilian Aircrew, and Contractor Aircrew performing Maintenance Engineering and Support Personnel (MESP) duties. It prescribes the medical standards required for performing MESP duties. Changes to the procedures in this publication are not authorized without approval of AFMC/SGPA. It does not apply to the Air Force Reserve Command nor Air National Guard units. The reporting requirements in this AFI are exempt from licensing in accordance with AFI 33-324, paragraph 2.11.10., *The Information Collections and Reports Management Program Controlling Internal, Public, and Interagency Air Force Information Collections.* Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF IMT 847, *Recommendation for Change of Publication*; route AF Form 847s from the field through the appropriate functional's chain of command and submit recommendations for improvements and/or changes in writing to AFMC/SGPA, 4225 Logistics Ave, RM N209, Wright-Patterson AFB OH, 45433. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 33-363, *Management of Records*, and disposed of in accordance with the Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) located at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm**.

SUMMARY OF CHANGES

This interim change implements new guidelines that clarify AFI 48-123, Medical Examinations and Standards and reflect repeal of the Don't Ask Don't Tell policy. It makes Flying and Special Operations applicable to civilian personnel employed by the Air Force to fill flying or special operational duty positions. It lists qualification criteria civilian AF physicians must have in order to make Aeromedical dispositions. Air National Guard (ANG) or Air Force Reserve Command (AFRC) Flight Surgeons may utilize their Flight Medicine credentials to make aeromedical dispositions while employed in a civilian Flight Medicine physician role. Aircrew and special duty personnel not collocated with an active duty 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/Special Operations Duty status after being examined by a military or civilian physician via "reach-back" consultation with a military Flight Surgeon as designated by AFMSA/SGPF. Cone Contrast Test (CCT) equipment will be sent to AF MTFs and ANG and AFRC units not co-located with an MTF no later than January 2011. Beginning 1 January 2011, or upon receipt of CCT equipment, all flying/special operational duty personnel or other career fields requiring color vision testing will be tested using both the CCT and PIP I/PIP II. Passing score on the CCT is defined as 75 or greater on each of the three colors, red, green and blue. For additional implementation instructions and disposition of Airmen with failing scores, refer to the AFMS KX at: **https://kx.afms.mil/kxweb/dotmil/kjPage.do?functionalArea=AerospaceMedicine&cid=CTB_122236**. AFSPC is the lead MAJCOM for the Cyberspace mission and has designated the AFSCs 1B4 and 17DXA, as well as several 17DXB crew positions require Combat Mission Ready status. These AFSCs and positions must now meet Space and Missile Operations Duty medical standards and have their duty and qualification status managed by AF Form 1042. For implementation instructions, refer to the AFMS KX at: **https://kx.afms.mil/kxweb/dotmil/kjPage.do?functionalArea=AerospaceMedicine&cid=CTB_122236** A margin bar (|) indicates newly revised material.

(AFMC) This document has been substantially revised and must be completely reviewed. This supplement provides major rewrite/reorganization and has aligned medical examination standards with AFI 48-123, *Medical Examinations and Standards, Flying and special Operational Duty.*

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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. Please see AFI 44-170, *Preventative Health Assessment* for further information.

1.1.1. **These standards apply to:**

1.1.1.1. Applicants for enlistment, commission, 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 active duty 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.

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, Preventative Health Assessment (PHA), Flying, Retirement, Separation, and DD Form 2697, Report of Medical Assessment. As long as all requirements are met, a medical examination may serve more than one purpose. **Note**: All induction physical examinations accomplished overseas by a medical treatment facility must be submitted through PEPP to AETC/SGPS. AETC/SGPS is the certifying authority for all accession physicals not done at a MEPS facility. AFRC/SG is the reviewing and certification authority for all AFRC enlistment and commissioning exams. Local Reserve medical units are the certification authority for enlistment exams on individuals who do not require a waiver.

1.2.1. **A medical examination is required before:**

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 special operational duty training.

1.2.1.2.1. Documents forwarded to certification/waiver authority (see as in 1.2.1.1. and 1.2.1.2.) will be electronically submitted (i.e., Physical Examination Processing Program (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. **Note**: All induction physical examinations accomplished overseas by a medical treatment facility must be submitted through PEPP to AETC/SGPS. AETC/SGPS is the certifying authority for all accession physicals not done at a MEPS facility. AFRC/SG is the reviewing and certification authority for all AFRC enlistment and commissioning exams. Local Reserve medical units are the certification authority for enlistment exams on individuals who do not require a waiver.

1.2.1.3. Termination of service when specified by **Chapter 8** of this instruction.

1.2.1.4. As required by AFI 44-170, *Preventative Health Assessment*.

1.2.1.5. As required for General Officer Boards.

1.2.2. Examiners: A credentialed military flight surgeon (FS) with current/active privileges in flight medicine will perform medical examinations on Air Force flying and/or special operational duty personnel. 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, AF Form 469, etc.) to the examinee's MAJCOM/SG for review and certification (including aircrew on joint/NATO tours, etc). When the exam is accomplished by a non-AF FS at a joint base, the AF flight FS must ensure sister-Service FS are trained in AF standards and associated paperwork. If trained, sister-Service FS can sign AF Form 1042 without AF FS review (with quality control accessed via FS peer review). If untrained, an AF FS must review all PHA and return to flying status (RTFS) documentation for AF aircrew. All aircrew members examined by a U.S. military FS and found qualified to perform flight duties will be returned to flying status upon completion of their examination.

1.2.2.1. Military flight surgeons must be credentialed and privileged at the examining facility and can be of any branch of the military service.

1.2.2.2. ANG/SG may delegate review and certification authority to current, trained and designated State Air Surgeon's on certain initial Flying Class (FC) III and return to FCIII, 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/SGPA prior to forwarding examinations.

1.2.2.3. A credentialed physician employed by the armed services (regardless of active duty status, to include TRICARE 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, accomplish all other non-flying medical examinations.

1.2.2.3.1. Physicians who are Air Force civilian employees may perform medical examinations on Air Force flying and/or special operational duty 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/commoditycouncil**.

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.

1.2.3.2. Military Entrance Processing Stations (MEPS) Examinations.

1.2.3.3. DODMERB contract sites.

1.2.3.4. Where no AF or DOD Military Treatment Facility (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. Treatment is not authorized for non-beneficiary applicants; however, every effort to secure positive transfer of care is mandatory in this instance.

1.2.4. **Required Baseline Tests:**

1.2.4.1. Blood type and Rh factor.

1.2.4.2. Glucose-6-Phosphate Dehydrogenase (G6PD).

1.2.4.3. Hemoglobin-S. Confirm positive results with electrophoresis.

1.2.4.4. Human Immunodeficiency Virus (HIV) Antibody. Confirm repeatedly positive enzyme immunoassay by Western Blot.

1.2.4.5. Pseudoisochromatic Plate (PIP) testing to determine color vision perception. **Note:** The optometrist must be basing their assessment of color vision on the PIP1 test.

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.)* **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 SF88 or DD 2807

that the test was not done, and must be completed upon arrival at their first training location/base. See US Code, Title 10, Subtitle A, Part II, Chap 49, para 978. and AFI 44-120, *Drug Abuse Testing Program*, Section G, para 13, 13.2.

1.2.4.8. Initial applicants for commission, enlistment, Flying Class II/IIU/III and SMOD, who are 40 years of age and older, are required to obtain an Exercise Tolerance Test (ETT) if their cardiac risk index (CRI) is 10,000 or greater.

1.2.4.9. Baseline electrocardiogram is required as part of all initial flying aircrew personnel examinations, and at age 35 and every five years thereafter.

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. All other entrants (e.g. AFROTC, prior service enlisted recruits and AF PIM Airmen) at their entry point or first permanent duty station.

1.2.5.5. Every effort must be made by ANG units to ensure enlistment physicals are accomplished at MEPS prior to scheduling at ANG Medical Group. Full completion of the MEPS physical is required before submission to ANG units. Certification and Waiver authority remains as described in **Attachment 2**. **Note:** See US Code, Title 10, Subtitle A, Part II, Chap 49, para 978 and AFI 44-120, Section G, para 13, 13.2.

1.2.6. **Records Transmittal.** Transmit reports of medical examination and supporting documents that contain sensitive medical data IAW AFI 41-210, *Patient Administration Functions* and system of records notice FO 44 SG E, Medical Record System and HIPAA guidelines.

Section 1C— Physical Profile System

1.3. Physical Profile System. This chapter, **1.7**, **Attachment 3**, and AFI 10-203 establishes procedures for the documentation and administrative management of Profiles. The physical profile system classifies individuals according to physical functional abilities. It applies to all active duty and ARC military personnel, Retired Regular AF Airmen of the PIM, as well as applicants for appointment, enlistment, and induction into military service. The goal is an accurate assessment of an individual's medical status.

1.3.1. Purpose of AF Form 422, *Physical Profile Serial Report*, is to standardize classification of an individual's physical functional abilities.

1.4. Establishing the Initial Physical Profile. The initial profile is established during the entry physical examination based on the results of that exam. The initial Form 422, verifies the initial profile serial of all individuals entering active duty and serves as the baseline Profile Serial

Report. Reasons for creating an AF Form 422 include, but are not limited to overseas PCS, retraining/special duty (SUAS-O duty, military training instructor duty or other special duty clearance), PME or training attendance, and medical disqualification from an AFSC, etc.

1.5. Responsibilities:

1.5.1. **Senior Profile Officer.**

1.5.1.1. Senior Profile officers are appointed by letter by the MTF Commander.

1.5.1.1.1. The standards experts in the AFMS are graduates of the Residency in Aerospace Medicine (RAM). Where a RAM is assigned, he/she will serve as the primary or senior profiling officer when more than one profile officer is appointed by the MTF Commander.

1.5.1.1.2. At MTFs where a RAM is not assigned, or the sole RAM is a squadron or group commander, the MTF/CC may appoint the physician most knowledgeable in physical standards as the senior profile officer.

1.5.1.2. The Senior Profile Officer is responsible for oversight of MTF profiling actions.

1.5.1.3. The Senior Profile Officer is responsible for resolving conflicts between line commanders, profile officers, and/or providers. Note: See AFI 10-203 for further details.

1.5.2. **Profile Officers.**

1.5.2.1. Profile officers are appointed by letter by the MTF Commander.

1.5.2.1.1. The Profile officer serves a critical review step in profiling and duty limitations. Thus, it is imperative that a limited number of profile officers be assigned at each MTF.

1.5.2.1.2. Profile officers will normally be flight surgeons credentialed and working in flight medicine. MAJCOM/SGP may authorize deviations when no flight medicine clinic exists or no flight surgeons are available for appointment by the MTF commander.

1.5.2.2. Profile officers will be familiar with this AFI and in particular, this chapter as well as **Chapter 1**, **Section 1C**, **Chapter 5**, **Section 5A**, **Chapter 6**, **G**, **H**, **I**, **J**, **K**, **G**, **Chapter 13**, **Attachment 3**, and AFI 10-203.

1.5.2.3. Profile Officers will ensure mission and patient interests are considered to maximize the benefit to both.

1.5.3. **Final validation and signature.** The Profile Officer performs final validation and signs all AF Forms 422 recommending any of the following:

1.5.3.1. Medical Disqualification from an AFSC.

1.5.3.2. Retraining.

1.5.3.3. All AF Form 422s reviewed for direct entry from active duty into any AF Commission Programs (i.e. Officer Training School (OTS), AF ROTC or Airman Education Commissioning Program).

1.5.4. **Public Health. Note:** Anytime Public Health or Force Health Management is referenced for Regular Air Force in this instruction, these functions will be performed by, Flight Medicine for AFRC; Health Technician for the ANG.

1.5.4.1. Public Health is the initial point of contact for all Profiling actions.

1.5.4.2. Public Health is responsible for the administrative tasks related to the profiling system in accordance with this instruction.

1.5.4.3. Public Health will serve as the communications link between squadron/unit commanders, supervisors, and the health care providers (to include the MTF/SGP (see below)).

1.5.4.4. Public Health will review and sign all profile actions.

1.5.4.5. Retraining applications will be reviewed by Public Health to ensure members are qualified for entry into the AFSC(s) for which the member is applying. Review of each AFSC's physical requirements are found in Officer and Enlisted Classification Directories. The AF Form 422 will indicate each of the selected AFSCs the member is and is not qualified to enter. When flying or special operational duty AFSCs are selected, **Chapter 6**, **G**, **H**, **I**, **J**, **K**, **G** will be reviewed for disqualifying defects. If defects are found the member will be informed and a determination of potential waiver action will be determined by a flight surgeon.

1.5.4.5.1. When a medical defect permanently precludes continued duty in a member's AFSC, but the member meets retention and deployment standards, a medical recommendation for retraining will be sent by Force Health Management to the MPF on an AF Form 422, with PULHES updated, and an AF Form 469 describing duty limitations. MEB is not required if member meets retention/deployed standards. See AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted) and* AFI 10-203, *Duty Limiting Conditions* for further information.

1.5.4.6. Public Health will review profiles for members on selection for assignment to overseas, remote/isolated Continental United States (CONUS), or combat zones assignment. **See Chapter 13.**

1.5.5. **Military Personnel Flight (MPF)/Military Personnel Section (MPS).**

1.5.5.1. Ensures Public Health is part of the process in clearing applicants for special duty assignments, PME, formal schools clearance, transfer to ARC, medical retraining requests, overseas Permanent Change of Station **(**PCS) clearances, security clearances (see DoDR 5210.42, *Nuclear Weapons Personnel Reliability Program (PRP) Regulation*, and AFMAN 10-3902, *Nuclear Weapons Personnel Reliability Program (PRP)* for specific procedures on PRP/SCI clearances).

1.5.5.2. Request and process overseas PCS clearances based on medical recommendations.

1.5.6. **Health Care Providers.**

1.5.6.1. Providers must be familiar with this chapter and **Chapter 1, Section 1C**, **Chapter 5**, **Section 5A** and **Attachment 3** prior to recommending any profiling actions.

1.5.6.2. Clinical profiling actions must be monitored through the facility peer review program (see AFI 44-119, *Medical Quality Operations*).

1.6. Accomplishing AF Form 422 - This how the revised AF Form 422 is completed.

1.6.1. **Patient Demographics.**

1.6.1.1. Force Health Management (FHM) (Flight Medicine for the AFRC; Health Technician for the ANG) personnel will complete patient demographics. Each block requires information. If that information does not exist, such as an e-mail address, the block must be dashed to indicate it was not omitted. Software that automatically populates this data is available in Preventative Health Assessment and Individual Medical Readiness (PIMR) and its use is required.

1.6.2. **Special Purpose Medical Clearance.**

1.6.2.1. A series of check boxes detailing the recommended action(s) following a diagnosis that may limit a member's overall status. This section is reviewed and completed by the healthcare provider, or in the case of medical clearance actions, Public Health (in consultation with a profile officer when appropriate). For overseas PCS screening, refer to AFI 36-2102, *Base Level Relocation Procedures*, and AFI 41-210, *Patient Administration*, for required actions. For retraining information, consult Enlisted/Officer Classification Guide on the Air Force Personnel Center website **https://gum.afpc.randolph.af.mil/cgi-bin/askafpc.cfg/php/enduser/home.php**. For PME attendance, obtain physical requirements from MPF.

1.6.3. **Profile Serial Update.**

1.6.3.1. This section is used to document an Airman's initial profile or for retraining. When accomplished, Public Health (Flight Medicine for the AFRC; Health Technician for the ANG) will complete and the Profile Officer will review, validate, and sign.

1.6.3.2. Refer to **Paragraph 1.7**, **Table 1.1** and **Attachment 3** for descriptions of the Physical Profile Serial Chart and appropriate entries for each letter.

1.6.3.3. **DELETED**

1.6.3.3.1. **DELETED**

1.6.3.3.2. **DELETED**

1.6.3.4. Strength Aptitude Test (SAT) is used to determine if members applying for retraining or special duty meet minimum strength requirements.

1.6.3.4.1. General Information:

1.6.3.4.2. Officer and Enlisted Directories establishes a SAT standard for each AFSC.

1.6.3.4.3. When AFPC requests a SAT evaluation in writing, Public Health reviews the accession MEPS physical and current medical records and completes the appropriate endorsement.

1.6.3.4.4. If the profile "X" factor equals or exceeds the SAT standard for the retraining AFSC, do not retest unless a medical condition is discovered changing the

SAT. If a medical condition is discovered, refer the individual to a health care provider for evaluation prior to SAT testing. See Officer and Enlisted Classification Directories for detailed requirements.

1.6.3.4.5. If the profile "X" factor is blank, contains a numeric character 1, 2, or 3, or is an alpha character less than the SAT standard, the SAT results are unsatisfactory.

1.6.3.4.6. A provider's review of medical records must indicate no potential medical reason that member cannot perform safe successful lifting attempt.

1.6.3.4.7. Refer member to the Fitness Center (gym) for administration of the SAT.

1.7. Physical Profile Serial Chart. See Table 1.1.

Table 1.1. Physical Profile Serial Chart.

P. Physical Condition.
P-1. Free of any identified organic defect or systemic disease.
P-2. 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 (i.e. G6PD deficiency).
P-3. Significant defect(s) or disease(s) under good control. Capable of all basic work commensurate with grade and position.
P-4. Organic defect(s), systemic and infectious disease(s) which has already undergone an MEB or ALC fast track as determined by the Deployment Availability Working Group (DAWG).
U. Upper Extremities.
U-1. Bones, joints, and muscles normal. Able to do hand-to-hand fighting.
U-2. 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.
U-3. 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
U-4. Strength, range of motion, and general efficiency of hand, arm, shoulder girdle, and back, includes cervical and thoracic spine severely compromised which has already undergone an MEB or ALC fast track as determined by the DAWG.
L. Lower Extremities.
L-1. Bones, muscles, and joints normal. Capable of performing long marches, continuous standing, running, climbing, and digging without limitation.
L-2. 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.
L-3. 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.

L-4. Strength, range of movement, and efficiency of feet, legs, pelvic girdle, lower back, and lumbar vertebrae severely compromised which has already undergone an MEB or ALC fast track as determined by the DAWG.

H. Hearing (Ears). See **Attachment 3** for hearing profile.

E. Vision (Eyes).

E-1. Minimum vision of 20/200 correctable to 20/20 in each eye.

E-2. 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.

E-3. Vision that is worse than E-2 profile.

E-4. Visual defects worse than E-3 which has already undergone an MEB or ALC fast track as determined by the DAWG.

S. Psychiatric.

S-1. Diagnosis or treatment results in no impairment or potential impairment of duty function, risk to the mission or ability to maintain security clearance.

S-2. 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.

S-3. 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.

S-4. Diagnosis or treatment result 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 and which has already undergone an MEB or ALC fast track as determined by the DAWG.

1.7.1. **AF Form 469.** AF Form 469 is a formal means to notify commanders and medical personnel of the impact of a condition on ability to perform military service. When determining a psychiatric profile, consider the airman's current duties and all foreseeable duties. It is the provider's responsibility, with the assistance of the commander, to become reasonably familiar with the duty demands of the airman being evaluated.

1.7.2. **Duty Limiting Conditions.** Duty limiting conditions are based on an operational risk management model. These decisions must be coupled to BOTH "mishap probability" (chance that medication or illness related duty impairment will occur) and the "hazard severity" (the danger to mission, security or safety should the impairment impact the person's function at a critical time).

1.7.3. **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*.

1.7.4. **Disorders That Are Unsuiting.** Disorders that are unsuiting for military service are managed administratively through the patient's chain of command and must not be confused with medical issues (See **Chapter 5**).

Section 1D—Medical Examination/Assessment/MISC--Accomplishment and Recordings

1.8. 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.

1.8.1. **Changes to existing SF 93 or DD 2807-1.** Make an addendum to the most current and complete Report of Medical History by adding any significant items of interval history since the last Report of Medical History was accomplished.

1.8.1.1. 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).

1.8.2. **Report of Medical History.** SF 93 (or DD Form 2807-1) is to be updated and attached to PEPP SF 88, *Medical Record-Report of Medical Examination*, DD Form 2808, *Report of Medical Examination*, or the PHA**,** where required, when medical examinations are accomplished for the following purposes:

1.8.2.1. Entry into active military service.

1.8.2.2. Appointment or enlistment in the Air Force or Reserve Forces.

1.8.2.3. Retirement or separation from active military service as specified by this instruction.

1.8.2.4. Periodic flying and non-flying assessments as specified in **Chapter 6** or AFI 44-170.

1.8.2.5. Whenever an examination is sent for higher authority review.

1.8.2.6. Whenever considered necessary by the examining health care provider; for example, after a significant illness or injury or commander directed physical assessment.

1.8.2.7. Examination of an ARC member. For ANG flying and non-flying PHAs, accomplish a PIMR generated SF 507 or AF WEB HA in place of updated SF 93/DD Form 2807-1.

1.8.2.8. Lost medical records. Accomplish a PHA with Report of Medical History. **Note**: Accomplish the Medical History electronically in PEPP when original history was done electronically.

1.8.3. **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.

1.8.3.1. Changes in Flight Status. Any significant medical condition requiring hospitalization, excusal, grounding, 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.

1.8.3.2. Updates. The interval medical history is recorded on SF 93, item 25 or continued on SF 507 and on DD 2807-1, item 30. Reference each update to the medical history with the current date, followed by any significant items of medical history since last examination. The most recent SF 93 or DD Form 2807-1 and all subsequent SF 507

must be filed together chronologically as all of these forms comprise the medical history. ANG will use PIMR generated SF 507 and AF WEB HA for interval history.

1.8.3.3. Significant Medical History. Use SF 93/DD Form 2807-1, waiver requests, 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.

1.8.3.4. 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)."

1.8.3.5. 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 initial SF 93 or DD Form 2807-1.

1.9. Medical Examinations. The results of medical examinations are recorded on SF 88/DD Form 2808 or approved substitutes in accordance with physical examination techniques.

1.10. DD Form 2697. DoD directs that DD Form 2697 be accomplished for all members separating or retiring from active duty, consult **Chapter 8**.

1.11. Adaptability Rating Military Aviation (ARMA) and other military duties , such as for Adaptability Rating for Control Duty (AR-GBC) or AR-SMOD 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 flying (or other duty), or evidence of a potential safety of flight risk, etc. (see **6.44.24** and physical examination techniques for further information).

1.12. 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, GO, NO-GO pills, etc., and also used as a deployment document IAW AFI 10-403, *Deployment, Planning and Execution*, paragraph 1.5.18.2. which requires the medical group commander to provide a current DD Form 2766 for all deploying personnel. **Note**: The similar AF Form 1480A, *Adult Preventive and Chronic Care Flowsheet*, may still be used.

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 ultimate waiver authority for all medical standards.

2.1.2. AF/SG may delegate waiver authority in writing to the Aerospace Medicine Consultant, AFMSA/SG3PF, or any residency-trained Aerospace Medicine Specialist.

2.2. AFMSA/SG3PF.

2.2.1. AFMSA/SG3PF may delegate waiver authority to MAJCOM/SG level or lower IAW **Attachment 2**. Certification and waiver of medical standards can only be delegated to a licensed physician.

2.3. MAJCOM/SGPA and NGB/SGPA.

2.3.1. Waiver authority as delegated in this AFI.

2.3.2. Liaison between MTF, medical squadrons, or medical groups and AFMSA.

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 will be completed not more than 30 days after they have been ordered/requested.

2.4.2. Ensures medical documents are filed in the health record and a completed copy filed IAW AFI 41-210.

2.4.3. MDG leadership determines which Primary Care Element will perform examinations for non-enrolled patients where required. Consult applicable directives and agreements for beneficiary benefits and restrictions on non-military examinees.

2.5. Aerospace Medicine Squadron/Flight Commander/ANG State Air Surgeon.

2.5.1. Ensures quality of medical examination process.

2.5.2. ANG State Air Surgeon serves as local Aeromedical certification/waiver authority for selected initial and trained flying personnel when so designated by ANG/SG and **Attachment 2**.

2.6. Senior Aerospace Medicine Physician (SGP).

2.6.1. The MTF/CC IAW AFI 48-101, *Aerospace Medicine Operations*, appoints in writing the SGP. This individual must be a credentialed active duty FS (or ARC FS, for ARC units) and must have active privileges in flight medicine at the MTF. **Note**: ANG MDG/CC appoints the Senior SGP in writing. This individual must be a credentialed flight surgeon (FS) and must have active privileges in flight medicine.

2.6.2. Serves as the MTF's senior profile officer and chairs the DAWG. **Note:** See AFI 10-203 for further information regarding the DAWG.

2.6.2.1. Provides training for medical staff on medical examinations and standards, to include profiling procedures as described in **Section 1C** and **Attachment 3**.

2.6.3. Serves as the local aeromedical certification and waiver authority when so designated by **Attachment 2** or MAJCOM/SGP written appointment.

2.6.4. 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.

2.6.5. Ensures commanders are aware of the fitness of the force.

2.7. Primary Care Elements (to include Flight Medicine).

2.7.1. Update results of required tests and examinations into the appropriate electronic database/program (PIMR, Air Force Complete Immunization Tracking Application (AFCITA), PEPP, AIMWTS, etc) after the PHA.

2.7.2. 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 aspect of the exams/assessments.

2.7.2.1. Refer to DoD 5210.42-R and AFMAN 10-3902 to determine applicable procedures.

2.7.2.2. Complete additional clinical follow-ups or consultations needed to finalize physicals and/or assessments or clearance.

2.7.3. Clinical. Clinical follow-ups for flying and special duty personnel are the responsibility of the Flight Medicine PCM team; this includes interim waiver evaluations as requested in AIMWTS. Interim evaluations must be performed and tracked by the FM PCM team or health systems technician for the ANG.

2.7.4. Provide any required follow-ups (including but not limited to Review in Lieu of (RILO) for members on ALC-C communicable disease, occupational health, deployment surveillance, profile management, and clinical preventive services) on enrolled or assigned patients.

2.7.5. Review PIMR status and determine qualification for retention and continued service IAW **Chapter 5** and deployment qualifications IAW **Chapter 13** during each encounter.

2.7.5.1. Ensure PIMR is updated upon every encounter.

2.7.5.2. 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 profile or DLC.

2.7.6. Flight Medicine Responsibilities: Complete all clinical components of flying, special operational duty and occupational health exams and/or assessments. Ensures each member of flight medicine subscribes to the Knowledge Junction of AF/SG3PF Aerospace Medicine at **https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=AerospaceMedicine&iPlanetDirectoryPro=AQIC5wM2LY4SfcwI6Yaaoj0rk1Qc2zQ0DXwDIlXtOdBsClM%3D%40AAJTSQACMDE%3D%23**

2.7.6.1. Ensure an effective grounding management program is maintained.

2.7.6.2. Initiate, track, and conduct follow up/interim evaluations or studies for all flying and Special Operational Duty waivers, to include entry into AIMWTS and any RILO required for continued service

2.7.6.3. Flight Surgeons are responsible for all required aeromedical summaries.

2.7.6.4. Flight Surgeons will act as occupational health consultants for all PCM teams.

2.7.7. Initiate line of duty (LOD) determination, AF Form 348, *Line of Duty Determination*, IAW AFI 36-2910, *Line of Duty (Misconduct) Determination* as appropriate.

2.8. Public Health (Force Health Management). Note: These functions are performed by a 4N/4A for ARC, as they do not have a FHM function (see ARC supplements for further clarification).

2.8.1. Is charged with the administrative oversight of PIMR and medical standards issues IAW AFI 48-101. Ensures each member of FHM is subscribed to the Knowledge Junction of AF/SG3PF Aerospace Medicine at **https://kx.afms.mil/kxweb/dotmil/kj.do?functionalArea=AerospaceMedicine&iPlanetDirectoryPro=AQIC5wM2LY4SfcwI6Yaaoj0rk1Qc2zQ0DXwDIlXtOdBsClM%3D%40AAJTSQACMDE%3D%23**

2.8.2. Performs administrative quality reviews of physical examinations, DLCs, and appropriate clearances before these documents are forwarded/leave the facility (except routine PHAs, and MEBs).

2.8.3. Keeps Primary Care Elements, medical facility executive leadership, unit health monitors, unit deployment managers, and unit/installation leadership informed of PIMR (to include PHA, Individual Medical Readiness (IMR), Occupational Health Examinations, and Immunizations) requirements and current status for all active duty and assigned civilian employees (as applicable).

2.8.4. Ensures Primary Care Elements are notified of the physical examination requirements IAW AFI 44-170.

2.8.5. Identifies any required physical examination documentation and data entry, and assist with scheduling exams for all non-enrolled patients requiring physical examinations.

2.8.6. Serves as the initial point of contact for examination requirements and scheduling to include PHA for non-enrolled examinees, AFROTC, OTS applicants and ARC members.

2.8.7. Manages and performs all Occupational Hearing Conservation audiograms (except at bases where separate Occupational Health sections are already established outside of PH) IAW AFOSH Standard 48-20, *Occupational Noise and Hearing Conservation Program*.

2.9. Member's Commander. Ensures the member is available for and completes examination including required follow-up studies for final disposition.

2.10. Member's Supervisor. Actively supports this AFI and coordinates with MTF personnel to ensure completion of examinations and follow-up testing of their subordinates. Ensures temporary medical and occupational restrictions are complied with until the process is completed. **Note:** ANG: Coordinates with MDG Personnel and ensures member follows up with Civilian Primary Care Manager for care as needed.

2.11. Member. Meets scheduled medical appointments as directed. Scheduled appointments are mandatory for members who are mobility restricted due to medical reasons and have not met an MEB/ Assignment Limitation Code C **(**ALC C) fast track for their condition (Code 31/37). Informs unit supervisor of required follow-up evaluations and appointments. Reports all medical/dental treatment obtained through civilian sources or any medical condition that might impact utilization and readiness of personnel to the appropriate military medical authority. See **Chapter 11** 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. Commissioning Physicals for United States Air Force Academy (USAFA) Cadets: 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 physicals must still be performed in their entirety.

3.1.2.1. 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.

3.1.2.2. 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.

3.1.2.3. Air Force Academy. Physical examination is medically certified/waived within 24 months of date of entry into the Academy.

3.1.2.4. AFROTC, HPSP, Air Force Academy program graduates: Physical examination is valid for 48 months from the date certified.

3.1.2.5. Officer Applicants for Conditional Reserve Status (CRS). Physical examination is within 24 months (Date of the examination, or the date of medical certification) from the date of application. **Note**: The validity period for initial qualification and commissioning examinations performed by DODMERB, MTFs, and MEPS may be extended for an additional two years beyond the original examination expiration or certification date, if the individual will be graduating from one of the programs noted in 3.1.2.4. above. An annual interval health survey (Updated medical history) and HIV/Urine Drug screen within two years of commissioning date must be accomplished (DoD Requirement). Graduates with significant medical changes may require a new complete commissioning physical.

3.1.2.6. Officer Applicants for Conditional Reserve Status (CRS). When required, within 24 months from the date of application.

3.1.2.7. ARC members. Applicants accessed into the ARC from any service component must provide a current AF Form 422 (within six months) to include PULHES, current DD Form 2697 and their last PHA.

3.1.2.8. Active duty members who are applying for commission must have a current PHA. ANG members applying for commission must have a current PHA.

3.1.3. **Flying Training.** Examination (Flying Classes I and IA) must be current within 48 months prior to starting Undergraduate Flying Training (UFT). The 48 month period begins from date of certification/waiver of the physical examination (e.g. Air Education and Training Command (AETC) AETC/SGPS certifies examination on 1 Jan 2008. The 48 month period expires 1 Jan 2012.). Medical history (SF 93/DD Form 2807-1) must be verified as current within 12 months prior to start of training. Must have current PHA in addition to certified IFC1/1A. **Note**: An initial certification examination does not exempt Active duty applicants from accomplishing their required PHA while awaiting training.

3.1.3.1. Undergraduate Flying Training (UFT) applicants must meet Flying Class I standards to be eligible for entry into the Medical Flight Screening (MFS) program. Remotely Piloted Aircraft (RPA) pilot applicants must meet IFC IIU 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 IIU standards, but do not require repeat MFS-N screening.

3.1.3.2. All initial applications for UFT and RPA pilot duty must pass MFS and MFS-N prior to beginning undergraduate pilot training or initial RPA pilot training. 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).

3.1.3.3. Pilot and Navigator candidates must have a current, certified Flying Class I/1A examination, respectively, on record. **Note**: While attending pilot and navigator training FCI/IA/ standards (as appropriate) apply. Upon graduation FCII standards apply.

3.1.3.4. The member's PHA should be current prior to beginning active Undergraduate Flying Training (UFT). See 3.1.8.1. If a member was not on Active Duty (e.g. AFROTC/OTS candidates) prior to arrival at UFT or is otherwise not PHA current, then member will have PHA accomplished during their in processing at the UFT base. PHA currency must be maintained throughout UFT.

3.1.4. **Banked Status.** UFT graduates waiting upgrade training and Aviation Service Code (ASC) 5J flyers are inactive, but are required to meet Flying Class II standards through annual PHAs with the flight surgeon.

3.1.5. **Inactive Flyers.** Inactive flyers that do not receive flying pay and hold an ASC of 6J, 6L, 7J, 8J, and 9J, (see **6.13**) are not required to maintain Flying Class II standards as outlined in **Chapter 6**.

3.1.6. Individuals selected to attend UFT and currently assigned to a non-rated position pending UFT report date. If the start of UFT 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 1A exam will be required with certification by AETC/SG or his/her designee. The requirements outlined in paragraph 3.1.2. and its sub-paragraphs apply.

3.1.7. Return-to-Active Duty Programs:

3.1.7.1. Rated Recall Applicants: Participants in a Voluntary Rated Recall Program must meet IFCII/IIU/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 is the enlistment/commissioning accession authority. See **Attachment 2, Table A2.1** for certification/waiver authority. **Note:** IFC physical is not required if the applicant separated from active duty within 6 calendar months. Their last PHA must be valid through the date of re-entry or a new IFCII/IIU/III physical will be required.

3.1.7.2. All other return-to-active duty applicants: All Airmen returning to active duty following ARC duty or break in service, or applying for initial active duty following ARC tours, must have an initial enlistment/commissioning/aviation (if appropriate) physical examination documented in PEPP if they have been off active duty for more than 6 months. If they have been off active duty for less than six months, a current/valid PHA will be used. If aviation waiver is required, submit through AIMWTS. AETC/SG is the enlistment/commissioning accession authority. **Note**: See **Attachment 2, Table A2.1**

3.1.8. All other initial examinations. All other initial examinations, including Flying Class III, Flying Class II (Flight Surgeon Duties), FCIIU (RPA pilot), ground based controller (GBC), RPA Sensor Operator (1U0X1), and Space and Missile Operations Duty (SMOD) are valid for 24 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.

3.1.8.1. Regardless of initial physical certification date, a PHA must be completed within three months of arriving at their first permanent duty station IAW AFI 44-170.

3.1.9. **General Officers, Aircrew, Special Operational Duty, and ARC Personnel** . Medical examinations are valid for one year or as specified in AFI 44-170.

3.1.10. **Active Duty (AD) personnel PHAs are valid for one year or as specified in AFI 44-170.** AF/SG or delegate as dictated by mission requirements may extend this expiration (See AFI 44-170).

3.1.11. **Physiological Training (9W)/Operational Support (ASC 9C) clearance examinations.** These examinations are valid until the end of the birth month of the next year from the date accomplished.

3.1.12. **PHA with associated paperwork less than 12 months. Note:** ARC members ordered to EAD with the regular AF do not need a physical examination since they need only meet **Chapter 5** standards. Most recent preventive health assessment 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 6130.4. 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 6130.4 implements DoD Directive 6130.3, DoDI 6130.4 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 6130.4 may be reviewed if the condition has resolved and a history of the condition is not disqualifying IAW this AFI.

4.1.2. DoD Directive 6130.3. 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 AFI 10-248, *Fitness Program* weight and body fat determinations remain part of accession physical standards. Weight and body fat standards are in AFI 10-248. See **Chapter 6**, paragraph **6.44.29** 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. Medical conditions or physical defects predating original enlistment, for the first six months of active duty 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 active duty 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, who have not completed 2 years with no break of their respective program.

4.2.7. AFROTC graduates whose active duty is delayed under applicable directives.

4.2.8. All individuals being inducted into the Armed Forces.

4.2.9. Individuals on Temporary Disability Retirement List (TDRL) who have been found fit upon reevaluation and wish to return to active duty. 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 active duty, (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). Section 5B establishes medical conditions and defects that are potentially disqualifying and/or preclude continued military service. While this is not an all-inclusive list, Airmen with conditions listed in this chapter require evaluation for continued military service (See paragraph 5.3). Other physical and mental conditions (see 5.3.21) that render an individual unsuited for duty or otherwise interfere with military service do not constitute a physical disability. The conditions in 5.3.21 are not eligible for MEB processing. Airmen with these conditions must be referred to their commander for possible administrative action if the disorder interferes with the individual's ability to deploy or perform duties consistent with their rank, AFSC, or duty position. These conditions are described in greater detail in paragraph 5.3.21 of this AFI, as well as AFI 36-3208, *Administrative Separation of Airmen*, para 5.11 and AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*.

5.1.1. **For Active Duty.** Review of potentially disqualifying medical conditions and defects via the DAWG IAW AFI 10-203. Processing is via MEB or ALC-fast track.

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, Chapter 3. If found to be In Line of Duty, processing occurs through the Active Duty process in paragraph **5.1.1** of this instruction. If potentially disqualifying defects are not In Line of Duty, worldwide duty processing occurs IAW AFI 10-203, Chapter 5.

5.2. Applicability. The retention standards apply to:

5.2.1. **Regular Air Force members on active duty, unless excluded from disability evaluation by applicable directives (e.g. Punitive actions).**

5.2.2. **All individuals who have separated or retired from active duty 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.**

5.2.3. **ARC and retired regular members if mobilized or otherwise recalled to active duty.**

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. **United States Air Force Academy (USAFA), AFROTC (after 2 contract years) cadets and Health Professions Scholarship Program (HPSP) when the student begins their third academic (USAFA Second Class) year.**

5.2.6. **Air Reserve Components.** The appropriate ARC surgeon (see **Attachment 2, note 8**) uses the standards in **Section 5B** and list of allowable prescribed medications to determine:

5.2.6.1. The medical qualification for continued military duty in the ARC for members not on EAD and not eligible for disability processing.

5.2.6.2. The medical qualification of officers and enlisted members from any service component requesting entrance into USAFR and ANG.

5.2.6.2.1. 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.

5.2.6.2.2. If more than 6 months (from date of separation) have elapsed, applicants must meet the standards of DoDI 6130.4.

Section 5B—Medical Standards for Continued Military Service (Retention Standards)

5.3. Standards. While this is not an all-inclusive list of unfitting/disqualifying conditions, Airmen with conditions listed in this section require evaluation for continued military service. These 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. The retention standard also requires the member to be fit for mobility status IAW Chapter 13. Also read paragraph 5.3.20 of this chapter when considering fitness for continued military duty. For active duty Airmen and ARC Airmen with duty-related (line-of-duty-yes conditions), refer members with disqualifying conditions to the DAWG. This also applies to AFROTC, and Cadets who may fall under retention standards based on 4.2.6., but not yet graduated. For Medical Evaluation Board (MEB) processing, see AFI 41-210. For ARC members with non-duty-related (line-of-duty-no) conditions, see Chapter 11. For Rated Recall Applicants and other Airmen returning to active duty who do not meet retention standards but are eligible for an assignment limitation code, AETC/SG will coordinate with AFPC/DPAMM through the ALC Fast Track pathway 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 worldwide duty. For elective surgery information, refer to AFI 44-102.

5.3.1. **Head.**

5.3.1.1. The loss of substance of the skull with or without prosthetic replacement accompanied by residual signs or symptoms that preclude satisfactory performance of duty or unrestricted station assignability.

5.3.1.2. An unprotected skull defect 3 centimeter (cm) in diameter or larger.

5.3.2. **Mouth, Nose, Pharynx, Larynx, and Trachea.**

5.3.2.1. Larynx.

5.3.2.1.1. Paralysis of the larynx. Characterized by bilateral vocal cord paralysis seriously interfering with speech or adequate airway.

5.3.2.1.2. Stenosis of the larynx. Of a degree causing respiratory compromise.

5.3.2.1.3. Obstructive edema. Obstructive edema of the glottis, if recurrent.

5.3.2.1.4. Obstructive sleep apnea (OSA) requiring Continuous Positive Airway Pressure (CPAP) device. OSA controlled by other means such as a dental device or surgery meet standards if control has been demonstrated by either a follow-on sleep study and/or maintenance of wakefulness test.

5.3.2.2. Nose, Pharynx, and Trachea.

5.3.2.2.1. Rhinitis. Atrophic rhinitis, characterized by bilateral atrophy of nasal mucus membranes, with severe crusting, concomitant severe headaches, and foul, fetid odor.

5.3.2.2.2. Sinusitis. Severe and chronic which is suppurative, complicated by polyps, or does not respond to treatment.

5.3.2.2.3. Stenosis of trachea causing respiratory embarrassment.

5.3.3. **Ears and Hearing.**

5.3.3.1. Ears.

5.3.3.1.1. Mastoidectomy. Followed by chronic infection requiring frequent or prolonged specialized medical care.

5.3.3.1.2. Infections of ears or mastoids. When satisfactory performance of duty is prevented or because of the requirement for extensive and prolonged treatment.

5.3.3.1.3. Meniere's syndrome. Recurring attacks of sufficient frequency and severity as to require frequent or prolonged medical care.

5.3.3.2. Hearing.

5.3.3.2.1. Hearing loss that precludes safe, effective performance of duty despite use of hearing aid. See **Attachment 3**.

5.3.4. **Dental.** Diseases and abnormalities of the jaw or associated tissues which despite treatment, prevent normal mastication, normal speech or the wearing of required life support or chemical/biological warfare ensemble, or which otherwise interferes with performance.

5.3.5. **Eyes and Vision.** All ophthalmologic cases must include visual acuity and automated threshold perimeter charts for peripheral visual field.

5.3.5.1. Any disease, injury, infection process, or sequelae involving the eye that is resistant to treatment and/or results in:

5.3.5.1.1. Distant visual acuity that cannot be corrected to the standards listed at paragraph **5.3.5.4.9**

5.3.5.1.2. The central field of vision in the better eye is less than 20 degrees from fixation in any direction.

5.3.5.1.3. Pterygium which encroaches on the cornea more than 3mm or interferes with vision, or is progressive, or causes refractive problems.

5.3.5.2. Current aphakia, history of pseudophakia, or current or history of dislocation of a lens.

5.3.5.3. Night blindness of such a degree that the member requires assistance in travel at night.

5.3.5.4. Even if the requirements in paragraph **5.3.5** above are met, the following manifestations of eye conditions are disqualifying:

5.3.5.4.1. Glaucoma with demonstrable changes in the optic disc or visual fields or not amenable to treatment.

5.3.5.4.2. Retinal detachment, bilateral.

5.3.5.4.3. Retinal detachment, unilateral, which results from organic progressive disease or results in uncorrectable diplopia, or visual acuity or visual field defects worse than specified above.

5.3.5.4.4. Enucleated eye.

5.3.5.4.5. Vision correctable only by the use of bilateral contact lenses or uncommon corrective devices, (e.g. telescopic lenses).

5.3.5.4.6. Aniseikonia when incapacitating signs or symptoms exist that are not easily treatable with standard ophthalmic spectacle lenses.

5.3.5.4.7. Diplopia when symptoms are severe, constant, and in a zone less than 20 degrees from the primary position.

5.3.5.4.8. Hemianopsia when bilateral, permanent, and based on an organic defect.

5.3.5.4.9. Visual acuity that cannot be corrected to at least:

Better eye	/Worse eye
20/20	20/400
20/30	20/200
20/40	20/100
20/50	20/80
20/60	20/60

5.3.5.4.10. History of approved keratorefractive surgery procedures, including Photorefractive Keratectomy (PRK), Laser Epithelial Keratomileusis (LASEK), epi-Laser Assisted In Situ Keratomileusis (epi-LASIK), and Laser-Assisted In Situ Keratomileusis (LASIK) accomplished to modify the refractive power of the cornea are disqualifying if the surgical outcome results in the member's inability to meet the above established vision standards or interferes with the member's ability to perform his/her duties. All other lamellar keratoplasty (LK), penetrating keratoplasty (PK),

and radial keratotomy (RK) procedures are disqualifying, regardless of visual outcome. See **Chapter 12** for additional information.

5.3.5.4.11. Corneal disorders. Keratoconus or any other corneal diagnoses that demonstrate progression, requires long term treatment, surgical intervention or result in spectacle corrected visual acuity below the level specified in **5.3.5.4.9**

5.3.5.4.11.1. Vascularization or opacification of the cornea for any cause which is progressive or reduces vision below standards.

5.3.6. **Lungs and Chest Wall.**

5.3.6.1. Active tuberculosis, where curative therapy requires 15 or more months.

5.3.6.2. Symptoms of chronic or recurrent pulmonary disease, or residuals of surgery, which preclude satisfactory performance of duty. These may include:

5.3.6.2.1. Significant fatigue or dyspnea on mild exertion supported by appropriate pulmonary function and blood gas studies.

5.3.6.2.2. Requirement for an inordinate amount of medical observation or care over prolonged periods.

5.3.6.3. Recurrent spontaneous pneumothorax when the underlying defect is not correctable by surgery.

5.3.6.4. Pneumonectomy.

5.3.6.5. Asthma, recurrent bronchospasm, or reactive airway disease.

5.3.7. **Heart and Vascular System.**

5.3.7.1. Heart disease.

5.3.7.1.1. Arteriosclerotic heart disease, when associated with congestive heart failure, persistent major rhythm disturbances, repeated angina attacks, silent ischemia at a low to moderate workload or objective evidence of myocardial infarction. The following considerations pertain to myocardial infarction:

5.3.7.1.1.1. Maintenance on any type of medication for the treatment or prevention of angina, congestive heart failure, or major rhythm disturbances (ventricular tachycardia, ventricular fibrillation, symptomatic paroxysmal supraventricular tachycardia, atrial flutter, or atrial fibrillation).

5.3.7.1.1.2. Individuals sustaining a myocardial infarct will have MEB or Assignment Limitation Code Request (ALC-R), or ARC non-duty related fitness for duty evaluation processing, within 12 months following infarction or when optimum medical benefit is achieved, whichever is sooner.

5.3.7.1.1.3. Refer to ARC supplements when managing cases on ARC members.

5.3.7.1.1.4. Final evaluation of cases for continued active duty, and where time permits, for separation or retirement, is conducted not more than 1 year post-infarct, provided the member's clinical course is uneventful.

5.3.7.1.2. Stress testing is required by medical and disability reviewing authorities in adjudication of infarction cases. The patient must achieve 85% of their maximum

predicted heart rate for age. If the heart rate is limited by required medicines (i.e. beta-blockers) then the patient must complete the end of stage 3 on a full Bruce exercise tolerance test.

5.3.7.1.2.1. Exercise Treadmill Test (ETT).

5.3.7.1.2.1.1. **DELETED**

5.3.7.1.2.1.2. ETT is considered abnormal if the patient develops any of the following:

5.3.7.1.2.1.2.1. Symptoms of angina or congestive heart failure.

5.3.7.1.2.1.2.2. Inadequate rise in systolic blood pressure (< 30 mmHg).

5.3.7.1.2.1.2.3. Horizontal or downsloping ST segment depression of to ≥ 0.10 mV for ≥ 80 ms.

5.3.7.1.2.1.2.4. ST segment elevation of ≥ 0.10 mV at 60 ms after the J-point.

5.3.7.1.2.1.2.5. Ventricular tachycardia.

5.3.7.1.2.1.2.6. Evidence of reversible or irreversible ischemia.

5.3.7.1.2.1.3. **DELETED**

5.3.7.1.2.1.4. **DELETED**

5.3.7.1.2.1.5. **DELETED**

5.3.7.1.2.1.6. **DELETED**

5.3.7.1.2.1.6.1. **DELETED**

5.3.7.1.2.1.7. **DELETED**

5.3.7.1.2.1.7.1. **DELETED**

5.3.7.1.2.1.7.2. **DELETED**

5.3.7.1.2.1.8. **DELETED**

5.3.7.1.2.1.8.1. **DELETED**

5.3.7.1.2.1.8.2. **DELETED**

5.3.7.1.2.1.8.3. **DELETED**

5.3.7.1.2.1.8.4. **DELETED**

5.3.7.1.2.2. Stress Imaging (if performed due to physician preference or after an abnormal exercise tolerance test) must include:

5.3.7.1.2.3. Left ventricular systolic function assessment.

5.3.7.1.2.4. History and physical, which documents:

5.3.7.1.2.4.1. History of significant arrhythmias.

5.3.7.1.2.4.2. History of angina.

5.3.7.1.2.4.3. Patient' s functional status, such as New York Heart Association (NYHA) or Canadian Heart classification of angina and heart failure.

5.3.7.1.2.4.4. Stress imaging is abnormal if there are any significant territories of reversible or irreversible ischemia.

5.3.7.1.3. Ventricular fibrillation or sustained ventricular tachycardia.

5.3.7.1.4. Pacemakers or implantable cardioverter-defibrillators.

5.3.7.1.5. Supraventricular tachycardia, unless successfully ablated, and not associated with structural heart disease.

5.3.7.1.6. Any type of atrial fibrillation or atrial flutter, unless single episode of atrial fibrillation clearly associated with reversible cause.

5.3.7.1.7. Myocarditis and degeneration of the myocardium.

5.3.7.1.8. Cardiomyopathy, any etiology, including hypertrophic obstructive type, idiopathic dilated type, toxic, restrictive.

5.3.7.1.9. Endocarditis, infectious (acute or subacute), and marantic.

5.3.7.1.10. Pericarditis.

5.3.7.1.10.1. Chronic constrictive pericarditis, unless successful surgery has been performed and return of normal hemodynamics objectively documented.

5.3.7.1.10.2. Chronic serous pericarditis.

5.3.7.1.11. Acute rheumatic valvulitis or sequelae of chronic rheumatic heart disease (see also, valvular heart disease below).

5.3.7.1.12. Symptomatic premature ventricular contractions which are significant enough to interfere with satisfactory performance of duty.

5.3.7.1.13. Symptomatic or asymptomatic second degree Type II or third degree atrioventricular block, or symptomatic second degree I atrioventricular block. Exception is atrioventricular blocks which are clearly associated with reversible cause.

5.3.7.1.14. Thromboangiitis obliterans.

5.3.7.2. Vascular Disease.

5.3.7.2.1. Peripheral and central vascular disease, if symptomatic, including claudication, skin changes or cerebrovascular events (including stroke, TIA, CVA, infarcts, etc.).

5.3.7.2.2. Periarteritis nodosa.

5.3.7.2.3. Chronic venous insufficiency (postphlebitic syndrome). When symptomatic or requiring elastic support or chronic anticoagulation.

5.3.7.2.4. Raynaud’s phenomenon, if frequent, severe, associated with systemic disease or would limit worldwide assignability.

5.3.7.2.5. Deep venous thrombosis with repeated attacks requiring treatment or prophylaxis, or pulmonary embolus.

5.3.7.2.6. Varicose veins. Severe and symptomatic.

5.3.7.2.7. Other Congenital and structural anomalies. A Patent Foramen Ovale, if not associated with embolism or migraines, is allowable.

5.3.7.2.8. Valvular heart disease, including:

5.3.7.2.8.1. Symptomatic mitral valve prolapse requiring treatment.

5.3.7.2.8.2. Moderate to severe aortic stenosis (valvular, subvalvular or supravalvular), even if asymptomatic.

5.3.7.2.8.3. Moderate to severe mitral regurgitation, any etiology, if symptomatic or associated with subnormal ejection fraction. Successful mitral repair with preservation of ejection fraction, no need for anticoagulants or anti-arrhythmics may be waived if exercise tolerance is normal, but DAWG review must precede surgery.

5.3.7.2.8.4. Severe valvular or subvalvular pulmonic stenosis. Successful correction of valvular pulmonic stenosis with balloon valvuloplasty may be waiverable, but DAWG review must precede the procedure.

5.3.7.2.8.5. Symptomatic mitral stenosis generally associated with mitral valve area less than 1.0 cm sq.

5.3.7.2.8.6. Severe aortic insufficiency if symptomatic associated with left ventricular dilation or dysfunction.

5.3.7.2.8.6.1. Recurrent syncope regardless of etiology unless clearly identified by a precipitating cause which can be avoided.

5.3.7.2.8.6.2. History of or ECG evidence of Brugada pattern, Congenital Long QT syndrome, arrhythmogenic RV caradiomyopathy (ARVC), or Hypertropic Cardiomyopathy.

5.3.7.2.8.7. Hypertensive cardiovascular disease.

5.3.7.2.8.7.1. Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status or history of hypertension associated with any of the following:

5.3.7.2.8.7.1.1. More than minimal demonstrable changes in the brain.

5.3.7.2.8.7.1.2. Heart disease related to the hypertension, including atrial fibrillation, moderate to severe left ventricular hypertrophy, and symptomatic systolic or diastolic dysfunction.

5.3.7.2.8.7.1.3. Unequivocal impairment of renal function.

5.3.7.2.8.7.1.4. Grade III (Keith-Wagener-Parker) changes in the fundi.

5.3.7.2.8.7.1.5. Multiple drug therapy requiring inordinate amount of medical supervision, or requiring recurrent laboratory monitoring, after initial medical stabilization on medication. A member should not be

deployed during the initial stabilization period while medication dosage is being adjusted.

5.3.7.2.8.8. Aneurysm or history of repair.

5.3.7.2.8.9. Reconstructive Surgery including:

5.3.7.2.8.9.1. Grafts.

5.3.7.2.8.9.2. Prosthetic devices that are attached to or implanted for cardiovascular therapeutic purposes, regardless of result. Intracoronary stents may, in certain instances, be acceptable without MEB if associated with a good result, no myocardial infarction has occurred, and a six-month post-procedure treadmill is non-ischemic. Fitness for Duty processing is required for ARC members 6-12 months following procedure with associated myocardial damage; three months if no myocardial damage.

5.3.7.2.8.9.3. Surgery of the heart, pericardium, or vascular system.

5.3.7.2.8.9.4. Member has undergone coronary vascular surgery, regardless of the result. Coronary angioplasty, may in certain instances, be acceptable without MEB if no myocardial infarction has occurred, a good result is obtained, and six month post-procedure treadmill or equivalent test is non-ischemic. **Note:** Refer to **Chapter 11** when managing cases on ARC members.

5.3.8. **Blood, Blood-Forming Tissue, and Immune System Diseases.**

5.3.8.1. Anemia, symptomatic.

5.3.8.2. Leucopenia, chronic.

5.3.8.3. Hemolytic disease, chronic. Symptomatic or with recurrent crises.

5.3.8.4. Polycythemia, symptomatic.

5.3.8.5. Purpura and other bleeding disorders.

5.3.8.6. Thromboembolic disease, except for acute, non-recurrent conditions..

5.3.8.7. Coagulopathies (with the exception of Von Willebrand's Disease see 5.3.21.2.5.).

5.3.8.8. Thrombocytopenia or thrombocytosis. Platelet counts less than 100,000/mm 3 or greater than 400,000 mm 3 are disqualifying and must be evaluated. Transient elevation of platelet counts due to acute illness (acute phase reactant) is not disqualifying.

5.3.8.9. Platelet dysfunctions.

5.3.8.10. Leukopenia (granulocytopenia). White blood cell counts must fall within the range of 3,500 to 12,000 cells/mm 3 -- counts in the range of 750 to 3,500 cells/mm 3 must be fully evaluated.

5.3.8.11. All leukemias and other myeloproliferative disorders.

5.3.8.12. All lymphomas, including mycosis fungoides and Sezary syndrome.

5.3.8.13. Plasma cell dyscrasias.

5.3.8.13.1. Multiple myeloma.

5.3.8.13.2. Macroglobulinemia.

5.3.8.14. Splenomegaly, chronic, inoperable.

5.3.8.15. Other such diseases when response to therapy is unsatisfactory or when therapy is prolonged or requires intense medical supervision such as use of anticoagulants or antiplatelet agents other than aspirin or persantine.

5.3.8.16. Immunodeficiency.

5.3.8.17. Sickle cell disease and heterozygous sickling disorders other than sickle cell trait are disqualifying. **Note**: Those individuals with sickling disorders who develop symptoms attributable to the trait must undergo MEB evaluation. Refer to ARC supplements for ARC members.

5.3.8.18. Miscellaneous conditions such as porpyria, hemochromatosis, and amyloidosis. osis, and amyloidosisdosis.

5.3.9. **Abdomen and Gastrointestinal System.**

5.3.9.1. Esophageal.

5.3.9.1.1. Achalasia (cardiospasm), manifested by dysphagia not controlled by dilation with frequent discomfort, or inability to maintain normal vigor and nutrition.

5.3.9.1.2. Esophagitis, persistent and severe.

5.3.9.1.3. Diverticulum of the esophagus that causes frequent regurgitation, obstruction, and weight loss, and does not respond to treatment.

5.3.9.1.4. Stricture of the esophagus that requires an essentially liquid diet, frequent dilation and hospitalization, and causes difficulty in maintaining weight and nutrition.

5.3.9.1.5. Other recurrent, incapacitating abdominal pain of such nature to prevent the member from performing his/her duties.

5.3.9.2. Gastritis. Severe, chronic gastritis with repeated symptoms requiring hospitalization and confirmed by gastroscopic examination.

5.3.9.3. Hernia.

5.3.9.3.1. Hiatal hernia with severe symptoms not relieved by dietary or medical therapy or with recurrent bleeding in spite of prescribed therapy.

5.3.9.3.2. Other types of hernias, if operative repair is contraindicated for medical reasons, or if not amenable to surgical repair.

5.3.9.4. Ulcer. Peptic, duodenal or gastric with repeated incapacitations or absences from duty because of recurrence of symptoms despite good medical management and supported by laboratory and X-ray evidence of activity or severe deformity.

5.3.9.5. Cirrhosis of the liver. Recurrent jaundice or ascites or demonstrable esophageal varices or history of bleeding from them.

5.3.9.6. Hepatitis. Chronic, when symptoms persist after a reasonable time following the acute stage and there is objective evidence of impairment of liver function or if member requires follow up/treatment beyond six months.

5.3.9.6.1. Any other chronic liver disease whether congenital or acquired.

5.3.9.7. Amebic abscess residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.

5.3.9.8. Pancreatitis, chronic. Recurrent pseudocystitis or frequent abdominal pain requiring hospitalization or steatorrhea, or disturbance of glucose metabolism requiring insulin.

5.3.9.9. Peritoneal adhesions. Recurring episodes of intestinal obstruction, characterized by abdominal colicky pain, and vomiting, and requiring frequent admissions to the hospital.

5.3.9.10. Granulomatous enteritis or enterocolitis or Crohn's disease.

5.3.9.11. Ulcerative colitis.

5.3.9.12. Stricture of rectum. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, and difficult bowel movements that require the regular use of laxatives, enemas, or repeated hospitalization.

5.3.9.13. Proctitis, chronic. Moderate to severe symptoms of bleeding, painful defecation, or tenesmus, and diarrhea with repeated admissions to the hospital.

5.3.9.14. Anus. Impairment of sphincter control with fecal incontinence.

5.3.9.15. Familial polyposis.

5.3.9.16. Surgery.

5.3.9.16.1. Colectomy, partial, when more than mild symptoms of diarrhea remain.

5.3.9.16.2. Colostomy, when permanent.

5.3.9.16.3. Enterostomy, when permanent.

5.3.9.16.4. Gastrectomy, total.

5.3.9.16.5. Gastrectomy, subtotal with or without vagotomy, or gastrojejunostomy or pyloroplasty with or without vagotomy, when, in spite of good medical management, the individual:

5.3.9.16.5.1. Develops incapacitating dumping syndrome.

5.3.9.16.5.2. Develops frequent episodes of incapacitating epigastric distress with characteristic circulatory symptoms or diarrhea.

5.3.9.16.5.3. Continues to demonstrate significant weight loss.

5.3.9.16.6. Gastrostomy, when permanent.

5.3.9.16.7. Ileostomy, when permanent.

5.3.9.16.8. Pancreatectomy, except for partial pancreatectomy for a benign condition that does not result in moderate residual symptoms.

5.3.9.16.9. Pancreaticoduodenostomy, pancreaticogastrostomy, and pancreaticojejunostomy.

5.3.9.16.10. Proctectomy.

5.3.9.16.11. Proctoplexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after appropriate treatment.

5.3.9.16.12. Gastrointestinal bypass or stomach stapling, or any other procedure to alter gastric volume for control of obesity.

5.3.10. **Genitourinary System.**

5.3.10.1. Genitourinary conditions.

5.3.10.1.1. Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.

5.3.10.1.2. Dysmenorrhea. Not amenable to treatment, and incapacitating.

5.3.10.1.3. Endometriosis. Symptomatic and incapacitating.

5.3.10.1.4. Hypospadias. Not amenable to treatment.

5.3.10.1.5. Incontinence of urine. Not amenable to treatment.

5.3.10.1.6. Kidney:

5.3.10.1.6.1. Calculus in kidney, symptomatic and incapacitating.

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

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

5.3.10.1.6.4. Hydronephrosis, more than mild, and causing continuous or frequent symptoms.

5.3.10.1.6.5. Hypoplasia of the kidney, associated with elevated blood pressure or frequent infections or reduction in renal function.

5.3.10.1.6.6. Nephritis, chronic, with renal function impairment.

5.3.10.1.6.7. Nephrosis, other than mild.

5.3.10.1.6.8. Pyelonephritis or pyelitis, chronic, which has not responded to medical or surgical treatment, with evidence of persistent hypertension or reduction in renal function.

5.3.10.1.7. Menopausal or premenstrual syndrome. Physiologic or artificial, significantly interfering with the satisfactory performance of duty.

5.3.10.1.8. Strictures of the urethra or ureter. Severe and not amenable to treatment.

5.3.10.1.9. Urethritis. Chronic, not responsive to treatment and necessitating frequent absences from duty.

5.3.10.2. Genitourinary and Gynecological Surgery.

5.3.10.2.1. Cystectomy.

5.3.10.2.2. Cystoplasty. If reconstruction is unsatisfactory, or if refractory symptomatic infections persist.

5.3.10.2.3. Nephrectomy. When after treatment, there is infection or pathologic change (anatomic or functional) in the remaining kidney.

5.3.10.2.4. Nephrostomy or pyelostomy, if drainage persists.

5.3.10.2.5. Gonadectomy. Bilateral, when following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.

5.3.10.2.6. Penis. Amputation of. When urine is voided in such a manner that clothing or surroundings are soiled, or results in severe mental symptoms.

5.3.10.2.7. Ureterointestinal or direct cutaneous urinary diversion.

5.3.10.2.8. Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

5.3.10.2.9. Ureteroplasty.

5.3.10.2.9.1. When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for nephrectomy.

5.3.10.2.9.2. When bilateral and surgical repair is unsuccessful and associated with significant complications or sequelae (for example, hydronephrosis, residual obstruction or therapeutically refractive pyelonephritis).

5.3.10.2.10. Ureterosigmoidostomy.

5.3.10.2.11. Ureterostomy. External or cutaneous.

5.3.10.2.12. Urethrostomy. External or when a satisfactory urethra cannot be restored.

5.3.10.2.13. Major abnormalities and defects of the genitalia such as change of sex, a history thereof, or complications (adhesions, disfiguring scars, etc.). Residual to surgical corrections of these conditions.

5.3.11. **Neurologic Disorders.**

5.3.11.1. Amyotrophic lateral sclerosis.

5.3.11.2. Myelopathic muscular atrophy, including residuals of poliomyelitis.

5.3.11.3. Progressive muscular atrophy.

5.3.11.4. Chorea. Chronic and progressive.

5.3.11.5. Friedreich's ataxia.

5.3.11.6. Hepatolenticular degeneration.

5.3.11.7. Seizure disorder. **Note:** For ARC members initiate WWD within 90 days of initial event (refer to ARC supplements).

5.3.11.7.1. Seizures following omission of prescribed medication or ingestion of alcoholic beverages are not indicative of the controllability of the disorder.

5.3.11.8. Migraine. Manifested by disabling attacks requiring frequent absences from duty and are unrelieved by treatment.

5.3.11.9. Multiple sclerosis.

5.3.11.10. Myasthenia gravis.

5.3.11.11. Transverse myelopathy.

5.3.11.12. Narcolepsy.

5.3.11.13. Paralysis agitans.

5.3.11.14. Peripheral nerve conditions such as:

5.3.11.14.1. Neuralgia, when symptoms are severe, persistent, and do not respond to treatment.

5.3.11.14.2. Neuritis or paralysis due to peripheral nerve injury, when manifested by more than moderate, permanent functional impairment.

5.3.11.15. Syringomyelia.

5.3.11.16. Other neurological conditions. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech, or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

5.3.12. **Axis I Diagnosis, and Other Mental Conditions.** MEB is indicated in those instances when a mental health condition precludes satisfactory performance of duty or worldwide assignability or deployment. An MEB must be done when a condition has caused or is expected to cause significant duty impairment or limitations for greater than one year and for conditions in which there is recurrent impairment or recurrent impairment is expected. Certain Axis I conditions make an airman unfit for duty and subject to MEB (refer to **5.3.12.2.5**). Axis II conditions can make a person unsuitable for further military service and subject to administrative separation. Incapacity because of illness (unfit for duty) must be distinguished from lack of motivation or underlying personality disorder (unsuitable for duty). Axis II conditions, when present with an Axis I condition can clearly worsen overall impairment and prognosis. MEB evaluation is required in those instances when an Axis I or Axis I combined with Axis II condition precludes satisfactory performance of duty or worldwide assignability. If a diagnosis which questions fitness for duty (Axis I) is made while a member is pending administrative separation, the member's commander contacts the local MPF and Staff Judge Advocate for specific guidance.

5.3.12.1. Any psychotic episode other than those with a brief duration, good prognosis and clearly identifiable and reversible cause must meet MEB.

5.3.12.2. Mental conditions requiring MEB:

5.3.12.2.1. Conditions that are expected to have persistent duty impairment (more than 1 year despite treatment).

5.3.12.2.2. Conditions associated with recurrent duty impairment (2 or more episodes of impairment in 12 months).

5.3.12.2.3. Conditions which require continuing psychiatric support (e.g. weekly psychotherapy in order to function) beyond one year.

5.3.12.2.4. Conditions requiring use of lithium, anticonvulsants, or antipsychotics for mood stabilization.

5.3.12.2.5. Individuals who experience recurrent depression or anxiety disorders, require psychiatric medication for greater than one year, who have been hospitalized for a psychiatric condition, require an evaluation by a military mental health provider. These cases warrant careful consideration of fitness for duty, worldwide assignability and deployability, given that adequate mental health support may not be available in all locations. Serious psychiatric illnesses (refer to criteria in **5.3.12.2.1-4** above) that result in hospitalization require a MEB. For ANG members on long-term antidepressant maintenance therapy even if asymptomatic or in remission, a WWD evaluation must still be forwarded to ANG/SGPA for consideration.

5.3.12.2.6. Following any active duty suicide attempt, the MTF SGH will lead a meeting to review the case and determine the medical disposition of the individual; this meeting must include at least one mental health provider. An active duty Airmen with a potentially medically disqualifying diagnosis will meet a medical evaluation board. For suicide attempts by ARC members, a fitness for duty determination will be instituted (See AFRC/SGP Consolidated Program Memorandum).

5.3.12.2.7. ARC members with an axis I diagnosis will receive a non-duty related fitness for duty evaluation. Reserve providers must look closely at any member on psychotropic drugs to determine if any axis I diagnosis exists. For AFRC members on psychotropic drugs for non-psychiatric diagnosis do not need a worldwide duty evaluation based on this section. For ANG members on SSRI medication for non-Axis II diagnosis for up to 90 days do not require a WWD evaluation. For all other questionable cases, please forward to ANG/SGPA for determination.

5.3.12.3. Certain psychiatric disorders render an individual unsuited for duty, rather than unfit, and are subject to administrative separation (IAW AFI 36-3208, para 5.11).

5.3.12.3.1. Substance use disorders may render an individual unsuitable and subject to administrative separation. Provisions for treatment and disposition are in appropriate directives (IAW AFI 44-121). Substance use alone is not a cause for referral to MEB even if there are recurrent duty restrictions/impairments. MEB evaluations are indicated only in those instances where substance use is the proximate result of a current or pre-existing Axis I condition.

5.3.12.3.2. Unsatisfactory duty performance due to personality disorders, adjustment disorders, factitious disorders, or sexual perversions may render an individual unsuitable as opposed to unfit and subject to administrative separation. Unless found fit for duty by the disability evaluation system, a separation for personality disorder is

not authorized if service-related PTSD is also diagnosed IAW DoDI 1332.14, *Enlisted Administrative Separations*. Consult legal for further disposition and clarification.

5.3.12.3.3. Learning Disorders. Individuals determined to have a primary mental deficiency or special learning defect which interferes with the satisfactory performance of duty are unsuitable and subject to administrative separation. Learning disorders that interfere with effective duty performance are dealt with through administrative channels.

5.3.12.3.4. Attention Deficit Hyperactivity Disorder (ADHD). Individuals diagnosed with ADHD must be carefully evaluated for suitability for continued service. Members with this condition do not merit a medical board disposition and may be managed administratively. If treatment with medication is required for adequate duty performance, referral to the unit commander for determination of administrative disposition is appropriate. The commander may seek administrative separation based on impaired performance or allow for continued duty if the value to the unit outweighs risks of requiring medication. If treatment with medication is not required for adequate duty performance, the member remains suited for continued military service. **Note**: ANG individuals diagnosed with ADHD must be carefully evaluated for suitability for continued service. If treatment with medication is required, a Worldwide Duty evaluation and waiver request to ANG/SG is required.

5.3.12.3.5. "Flying phobia" of sufficient magnitude to preclude military air transportation is dealt with administratively unless the condition is the proximate result of an Axis I condition other than simple phobia.

5.3.13. **Extremities.**

5.3.13.1. Upper extremities.

5.3.13.1.1. Amputation of part or parts of an upper extremity that results in impairment equivalent to the loss of use of a hand.

5.3.13.1.2. Joint ranges of motion, which do not equal or exceed the following:

5.3.13.1.3. For shoulder:

5.3.13.1.3.1. Forward elevation to 90 degrees.

5.3.13.1.3.2. Abduction to 90 degrees.

5.3.13.1.4. For elbow:

5.3.13.1.4.1. Flexion to 130 degrees.

5.3.13.1.4.2. Extension to 45 degrees of flexion.

5.3.13.1.4.3. Chronic dislocation, when not reparable or when surgery is contraindicated.

5.3.13.2. Lower Extremities.

5.3.13.2.1. Recurrent hip dislocation.

5.3.13.2.2. Amputation of a toe or toes that precludes the ability to run or walk without a perceptible limp or to perform duty in a satisfactory manner.

5.3.13.2.3. Any loss greater than specified above to include foot, leg, or thigh.

5.3.13.2.4. Feet:

5.3.13.2.4.1. Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms, or severe with arthritic changes.

5.3.13.2.4.2. Pes planus, symptomatic, more than moderate with pronation on weight bearing which prevents the wearing of a military shoe, or when associated with trophic changes.

5.3.13.2.4.3. Talipes cavus when severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, or which prevents the wearing of a military shoe.

5.3.13.2.5. Internal derangement of the knee.

5.3.13.2.5.1. Residual instability following remedial measures if more than moderate in degree or with recurring episodes of effusion or locking, resulting in frequent incapacitation.

5.3.13.2.5.2. If complicated by arthritis.

5.3.13.2.6. Joint Ranges of Motion. Motion that does not equal or exceed the measurements listed below:

5.3.13.2.6.1. Hip:

5.3.13.2.6.1.1. Flexion to 90 degrees.

5.3.13.2.6.1.2. Extension to 0 degrees.

5.3.13.2.6.2. Knee.

5.3.13.2.6.2.1. Flexion to 90 degrees.

5.3.13.2.6.2.2. Extension to 15 degrees.

5.3.13.2.6.3.3. Shortening of an extremity, which exceeds 5 centimeters (2 inches).

5.3.13.2.7. Miscellaneous.

5.3.13.2.7.1. Arthritis.

5.3.13.2.7.1.1. Arthritis due to infection associated with persistent pain and marked loss of function, with X-ray evidence, and documented history of recurrent incapacitation.

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

5.3.13.2.7.1.3. Osteoarthritis, with severe symptoms associated with impairment of function, supported by X-ray evidence and documented history

of recurrent incapacity for prolonged periods.

5.3.13.2.7.1.4. Rheumatoid arthritis or rheumatoid myositis.

5.3.13.2.7.2. Chondromalacia or Osteochondritis dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function, or with severe residuals from surgery.

5.3.13.2.7.3. Fractures.

5.3.13.2.7.3.1. Malunion when, after appropriate treatment, there is severe malunion with marked deformity or more than moderate loss of function.

5.3.13.2.7.3.2. Nonunion when, after an appropriate healing period, the nonunion persists with severe loss of function.

5.3.13.2.7.3.3. Bone fusion defect when manifested by severe pain or loss of function.

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

5.3.13.2.7.4. Joints.

5.3.13.2.7.4.1. Arthroplasty, with severe pain, limitation of motion, and limitation of function, joint prosthesis or total joint replacement.

5.3.13.2.7.4.2. Bony or fibrous ankylosis, with severe pain involving major joints or spinal segments, or ankylosis in unfavorable positions or ankylosis with marked loss of function.

5.3.13.2.7.4.3. Contracture with marked loss of function and the condition is not remediable by surgery.

5.3.13.2.7.4.4. Loose bodies within a joint with marked functional impairment complicated by arthritis to such a degree as to preclude favorable results of treatment.

5.3.13.2.7.5. Muscles. Flaccid or spastic paralysis or loss of substance of one or more muscles, producing loss of function, which precludes satisfactory performance of military duty.

5.3.13.2.7.5.1. Myotonia congenita, significantly symptomatic.

5.3.13.2.7.6. Osteitis deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

5.3.13.2.7.7. Osteoarthropathy. Hypertrophic, secondary, with severe pain in one or multiple joints and with moderate loss of function.

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

5.3.13.2.7.9. Tendon transplant. Unsatisfactory restoration of function.

5.3.14. **Spine, Scapulae, Ribs, and Sacroiliac Joints.**

5.3.14.1. Congenital anomalies presenting functional impairment of a degree to preclude the satisfactory performance of duty.

5.3.14.2. Spina bifida, with demonstrable signs and moderate symptoms of root or cord involvement.

5.3.14.3. Coxa vara, more than moderate with pain, deformity and arthritic changes.

5.3.14.4. Herniation of nucleus pulposus, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

5.3.14.5. Spondylolysis or spondylolisthesis, when symptoms and associated objective findings are of such a degree as to require repeated hospitalization or frequent absences from duty.

5.3.14.6. Deviation or curvature of spine. Scoliosis exceeding 30 degrees lumbar or thoracic curvature, or interfering with function or wear of military uniform or equipment. Kyphysis/lordosis exceeding 55 degrees or interfering with function or wear of military uniform

5.3.15. **Skin and Cellular Tissues.**

5.3.15.1. Acne, severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wear of the uniform or use of military equipment.

5.3.15.2. Atopic dermatitis, severe or requiring frequent hospitalization.

5.3.15.3. Cysts and tumors. Refer to paragraph **5.3.18**

5.3.15.4. Dermatitis herpetiformis, which fails to respond to therapy.

5.3.15.5. Eczema, chronic, regardless of type, when there is moderate involvement or when there are repeated exacerbations in spite of continuing treatment.

5.3.15.6. Elephantiasis or chronic lymphedema, not responsive to treatment.

5.3.15.7. Epidermolysis bullosa.

5.3.15.8. Erythema multiforme, severe, and chronic or recurrent.

5.3.15.9. Exfoliative dermatitis, chronic.

5.3.15.10. Fungus infections, superficial, if not responsive to therapy and resulting in frequent absences from duty.

5.3.15.11. Hidradenitis, suppurative, and folliculitis decalvans.

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

5.3.15.13. Leukemia cutis and mycosis fungoides.

5.3.15.14. Lichen planus, generalized and not responsive to treatment.

5.3.15.15. Lupus erythematosus, chronic discoid variety with extensive involvement or when the condition does not respond to treatment.

5.3.15.16. Neurofibromatosis, if disfigurement is extensive or when associated with manifestation of other organ system involvement.

5.3.15.17. Pemphigus, not responsive to treatment and with moderate constitutional or systemic symptoms.

5.3.15.18. Psoriasis or parapsoriasis, extensive and not controlled by treatment or controllable only with potent cytotoxic agents.

5.3.15.19. Radiodermatitis, if resulting in malignant degeneration at a site not amenable to treatment.

5.3.15.20. Scars and keloids, so extensive they seriously interfere with the function of the body area or they interfere with proper fit and wear of military equipment.

5.3.15.21. Tuberculosis of the skin, if not responsive to therapy. Refer to paragraph **5.3.18**

5.3.15.22. Ulcers of the skin, not responsive to treatment after an appropriate period of time or if they result in frequent absences from duty.

5.3.15.23. Urticaria, chronic, severe, and not amenable to treatment.

5.3.15.24. Other skin diseases, if chronic or of a nature that requires frequent medical care or interferes with the satisfactory performance of military duty.

5.3.16. **Endocrine and Metabolic Conditions.**

5.3.16.1. Acromegaly.

5.3.16.2. Adrenal hyperfunction, not responding to therapy.

5.3.16.3. Adrenal hypofunction.

5.3.16.4. Diabetes insipidus, requiring antidiuretic hormone replacement therapy.

5.3.16.5. Diabetes mellitus, diagnosed, including diet controlled and those requiring insulin or oral hypoglycemic drugs**. Note:** The criteria for the diagnosis of diabetes consist of (a) diabetic symptoms with a casual glucose greater than or equal to 200 mg/dl, (b) Fasting plasma glucose greater than or equal to 126 mg/dl, or (c) 2 hour plasma glucose greater than or equal to 200 mg/dl during an oral glucose tolerance test (OGTT). The diagnosis is considered provisional until confirmed by any of these methods on a subsequent day. Values for fasting plasma glucose greater than or equal to 110 but less than 126 mg/dl are considered to represent impaired fasting glucose; 2 hours post-prandial glucose levels greater than or equal to 140 but less than 200 mg/dl represent impaired glucose tolerance.

5.3.16.6. Gout, with frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.

5.3.16.7. Hyperinsulinism, when caused by a malignant tumor, or when the condition is not readily controlled.

5.3.16.8. Hyperparathyroidism, when residuals or complications such as renal or bony defects preclude satisfactory performance of military duty.

5.3.16.9. Hyperthyroidism, with severe symptoms that do not respond to treatment.

5.3.16.10. Hypoparathyroidism, with objective evidence and severe symptoms not controlled by maintenance therapy.

5.3.16.11. Osteomalacia, when residuals after therapy are of such degree or nature as to limit physical activity to a significant degree.

5.3.17. **Systemic Disease.**

5.3.17.1. HIV seropositivity, confirmed.

5.3.17.2. Amyloidosis, generalized.

5.3.17.3. Dermatomyositis polymyositis complex.

5.3.17.4. Leprosy, any type.

5.3.17.5. Lupus erythematosus, disseminated, chronic.

5.3.17.6. Myasthenia gravis.

5.3.17.7. Mycoses, active, not responsive to therapy, or requiring prolonged treatment, or when complicated by disqualifying residuals.

5.3.17.8. Panniculitis, relapsing, febrile, nodular.

5.3.17.9. Porphyria.

5.3.17.10. Sarcoidosis, progressive, with severe or multiple organ involvement and not responsive to therapy (see paragraph **5.3.6**).

5.3.17.11. Scleroderma, generalized or of the linear type which seriously interferes with the function of an extremity or body area involved or progressive systemic sclerosis including CREST Syndrome (calcinosis, Raynaud's phenomenon, esophageal hypomotility, sclerodactyly, and telangiectasia).

5.3.17.12. Tuberculosis, generalized.

5.3.17.13. Other autoimmune diseases requiring immunomodulating medications.

5.3.18. **Tumors and Malignant Diseases.**

5.3.18.1. Malignant neoplasms (including carcinomas in-situ). Malignancies that respond to treatment may require follow-up care that impacts deployability. Malignant neoplasms that are unresponsive to therapy, or have residuals of treatment, are in themselves unfitting under other provisions of this chapter. All malignancies except those listed in 5.3.18.4. require MEB (ALC Fast Track package, at minimum).

5.3.18.2. Neoplastic conditions of lymphoid and blood-forming tissues that are unresponsive to therapy or when the residuals of treatment are in themselves unfitting under other provisions of this chapter. Neoplastic conditions that respond to treatment may require follow-up care that may impact deployability.

5.3.18.3. Ganglion neuroma or meningeal fibroblastoma when the brain is involved.

5.3.18.4. Benign neoplasms, when the condition prevents the satisfactory performance of duty and the condition is not remediable or a remedial operation is refused. **Note:** Basal cell and squamous cell carcinomas and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which

have been treated with electrodessication and curettage by a dermatologist credentialed to perform this procedure) are exempted from Tumor Board Action and do not require MEB.

5.3.19. **Sexually Transmitted Diseases.**

5.3.19.1. Symptomatic neurosyphilis, in any form.

5.3.19.2. Complications or residual of sexually transmitted disease, of such chronicity or degree of severity the individual is incapable of performing duty.

5.3.20. **General and Miscellaneous Conditions and Defects.**

5.3.20.1. The individual is precluded from a reasonable fulfillment of the purpose of his or her employment in the military service.

5.3.20.2. 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.

5.3.20.3. The individual's retention in the military service would prejudice the best interests of the government. Questionable cases are referred to MEB or to the appropriate ARC surgeon for those ARC members who are not on EAD and are not authorized disability processing.

5.3.20.4. The individual has an EPTS defect or condition which may affect their retainability for continued military service and for which corrective surgery is contemplated.

5.3.20.5. Individuals requiring exemption from one or more components of the fitness test for greater than one year do not require MEB or ALC-C fast track unless one of the following conditions applies.

5.3.20.6. The individual's travel by military air transportation is precluded for medical reasons. (See paragraph **5.3.12.3.5** concerning "flying phobia").

5.3.20.7. The individual has an assignment canceled due to a medical condition. Present case to the DAWG within 10 calendar days. The DAWG must refer cases to AFPC/DPAMM if appropriate.

5.3.20.8. The individual continues to have a mobility limiting condition 1 year after the defect became limiting and has not yet met an MEB or Assignment Limitation Code Fast Track (ALC-FT).

5.3.20.9. The individual has been hospitalized 90 calendar days and return to duty within 3 more months is not expected. MEB or ALC fast track as determined by the DAWG must be accomplished when the patient's future qualification for further military service is foreseeable and must not be delayed until receipt of maximum hospital benefit.

5.3.20.10. The individual refuses required medical, surgical, or dental treatment or diagnostic procedures and the condition renders them not qualified for retention.

5.3.20.11. The individual requires determination of his or her competency for pay purposes.

5.3.20.12. 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.

5.3.20.13. The individual has coexisting medical defects that are thought to be the primary cause of unacceptable behavior or unsatisfactory performance.

5.3.20.13.1. If an individual's commander feels that a medical condition causes sufficient absences from duty that interferes with mission accomplishment, the commander may at their discretion request medical evaluation to determine fitness for continued military service.

5.3.21. **General Conditions That Interfere With Military Service (See AFI 36-3208, para 5.11 and AFI 36-3212).**

5.3.21.1. Certain conditions render an individual unsuited for duty, rather than unfit, and are subject to administrative separation (IAW AFI 36-3208, para 5.11). Discharge may be considered when the physical or mental condition interferes with assignment or duty performance (as judged by the commander).

5.3.21.2. Common diagnoses, from AFI 36-3208 are summarized below for ease of standards application. The referenced AFI is the source instruction and must be consulted for details and specific cases.

5.3.21.2.1. Mental health, substance abuse, and psychiatric conditions are listed within para 5.3.12.3. above.

5.3.21.2.2. Psuedofolliculitis barbae of the face and/or neck.

5.3.21.2.3. Significant allergic reaction to stinging insect venom.

5.3.21.2.4. Unsanitary habits including repeated venereal disease infections.

5.3.21.2.5. Certain anemias (in the absence of unfitting sequelae) including G6PD deficiency, other inherited anemia traits, and Von Willebrand's disease.

5.3.21.2.6. Inability to receive all mobility required immunization. **Note:** e.g. anthrax immunization is required for some, but not all deployments. If an individual must deploy to a location requiring this immunization and is unable to receive it, a waiver for deployment can be obtained from the gaining theater commander.

5.3.21.2.7. Allergic manifestations: A reliable history of generalized reaction with anaphylaxis to stinging insects. A reliable history of a moderate to severe reaction to common foods, spices or food additives.

5.3.21.2.8. Enuresis.

5.3.21.2.9. Sleepwalking and/or Somnambulism.

5.3.21.2.10. Dyslexia and Other Learning Disorders see para 5.3.12.3.3.

5.3.21.2.11. Attention Deficit Hyperactivity Disorder see para 5.3.12.3.4.

5.3.21.2.12. Incapacitating fear of flying confirmed by a psychiatric evaluation.

5.3.21.2.13. Airsickness, motion, and/or travel sickness.

5.3.21.2.14. Certain mental disorders including adjustment disorders, impulse control disorders and factitious disorders see para 5.3.12.3.2.

5.3.21.2.14.1. Personality disorder and post-traumatic stress disorder require special processing IAW AFI 36-3208, para 5.11.10.

5.3.21.2.15. Uncomplicated alcoholism or other substance use disorder see para 5.3.12.3.1.

5.3.21.2.16. Sexual gender and identity disorders, including sexual dysfunctions and paraphilias see para 5.3.12.3.2.

5.3.21.2.17. Obesity.

5.3.21.2.18. Overheight.

5.3.21.2.19. Allergy to uniformed clothing.

5.3.21.2.20. **(DELETED)**

Chapter 6

FLYING AND SPECIAL OPERATIONAL DUTY

Section 6A— Medical Examination for Flying and Special Operational Duty

6.1. Flying and Special Operational Duty Examinations.

6.1.1. **Medical Classifications.** There are eight medical classes that qualify an individual for flying duty. All Air Force applicants requesting an Air Force flying or special duty physical examination must process through an Air Force MTF or MFS (as applicable) to have their physical examinations/waivers processed. All of these physicals will be processed utilizing PEPP and/or AIMWTS. Any exception to accomplishing these exams at facilities other than Air Force facilities must be coordinated with AETC/SGPS. Reserve FCIII applicants may be processed through the Reserve Medical Unit (RMU).

6.1.1.1. Flying Class I qualifies for selection into MFS, and once MFS is passed, commencement of undergraduate pilot training (UPT).

6.1.1.2. Flying Class IA qualifies for selection and commencement of UNT.

6.1.1.3. Flying Class II qualifies rated officers (pilots, to include Remotely Piloted Aircraft (RPA) pilots, navigators/electronic warfare officers and flight surgeons), flight surgeon applicants and pilots.

6.1.1.3.1. 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 and FCIIB will be documented in the remarks section of the AF Form 1042, Recommendation for Flying or Special Operation Duty.

6.1.1.3.2. Flying Class IIA qualifies rated officers for duty in low-G aircraft (e.g. tanker, transport, bomber, T-43, T-1).

6.1.1.3.3. Flying Class IIB qualifies rated officers for duty in non-ejection seat aircraft.

6.1.1.3.4. Flying Class IIC qualifies rated officers for aviation duty as specified in the remarks section of AF Form 1042, as annotated on the Aeromedical Summary (AMS), or SF 88 or DD Form 2808, and as noted in AIMWTS. Example: Restricted to multi-place aircraft.

6.1.1.3.5. Flying Class IIU qualifies rated officers for RPA pilot duties only.

6.1.1.4. Flying Class III qualifies individuals for non-rated duties in ASC 9D, 9E, 9W and other relevant ASCs. USAFA cadets participating in USAFA cadet airmanship program, see **6.48.9**

6.1.1.5. Special Operational Duty: Some career fields have unique operational requirements that drive additional medical evaluations. These include but are not limited to GBC (**Section 6I**), SMOD (**Section 6J**), and other Miscellaneous Duties (**Section 6K**).

6.1.2. **Medical examinations are required when:**

6.1.2.1. Individual applies for initial flying duty (all classes) except as specified in **Attachment 2, note 7**.

6.1.2.2. Officers holding comparable status in other US military services apply for Air Force aeronautical ratings (FC II, SF 88/DD Form 2808, SF 93, DD Form 2807-1, etc.).

6.1.2.3. Personnel, including personnel of the ARC, are ordered to participate in frequent and regular aerial flight (FC II/III, SF 88/DD Form 2808, SF 93, /DD Form 2807-1, etc.).

6.1.2.4. Flying personnel, including personnel of the ARC, are suspended from flying status for 12 months or more for medical reasons, applying for return to flying duties (FC II/III, SF 88, DD Form 2808/SF 93, DD Form 2807-1, and AMS for any disqualifying condition etc. for ARC, and (PHA with AMS for Active Duty Air Force).

6.1.2.5. Flying personnel are ordered to appear before a Flying Evaluation Board (FEB). (See AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Badges*.) (Use FC II/III, SF 88, DD Form 2808/SF 93, DD Form 2807-1, etc. for ARC, and PHA with AMS for Active Duty Air Force.) **Note:** Air sickness may be managed IAW AETCI 48-102, *Medical Management of Undergraduate Flying Training Students*. If no underlying medical pathology and unresponsive to the measures discussed in **6.44.30.1.5** this becomes an administrative function.

6.1.2.6. All members on flying status or special duty status annually. See AFI 44-170 guidance for specific variations and details.

6.1.2.7. Return to flying status after a break in flying duties. **Note:** If the break is less than 12 months, the local flight surgeon clears the member for flying duty. If the break has been greater than 12 months, forward to the gaining MAJCOM/SG for review and certification. All waivers must go to the gaining MAJCOM/SG. Refer to AFI 11-402 for further information concerning aviation service requalification.

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. Flying personnel report to a new base. **Note:** Not required for TDY or deployment.

6.1.3.1.4. For the following initial exams the examining flight surgeon handles disqualifying defects in the following manner:

6.1.3.1.4.1. Complete all Flying Class I and IA Undergraduate Flight Training (UFT), Initial Flying Class II (Flight Surgeon (FS)), FCIIU, Initial Flying Class III, GBC, air vehicle operator, or space and missile operation duty examinations, regardless of the nature of disqualifying defect. Send completed SF 88/DD Form 2808 and SF 93/DD Form 2807-1, and all allied documents to the appropriate certifying authority or requesting agency, such as MPF, Air Force Recruiting, AFROTC Detachment, etc. The examining flight surgeon completely identifies,

describes, or 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**. These exams must not be disqualified at the base but must be completed and forwarded to the certification/wavier authority. **Note:** All IFCIII physicals are required to have color vision, depth perception, height, hearing, distant and near visual acuity testing results recorded even if a specific AFSC does not require the standard to qualify for a particular career field. Results must be recorded and information put into PEPP and AIMWTS.

6.1.3.1.4.2. Forward aeromedical disqualifications to the MAJCOM/SG for review and disposition. Local medical facilities do not have disqualification certification authority. MAJCOM/SG will notify AFMSA/SG3PF of disqualified cases (rated pilots only). AFMSA/SG3PF will notify FAA of medical disqualification for rated pilots only.

Section 6B— Waiver Information

6.2. General Waiver Information. For applicants applying for initial and special operational flying duties who are not currently already in the military, accessions and enlistments standards in **Chapter 4** **apply as well as appropriate flying or special operational duty standards that they are applying for.** **Chapter 5** applies to personnel already serving as active duty or ARC. (example, AD SSgt applying for IFCI duty must meet retention standards in **Chapter 5** as well as IFCI standards). The medical conditions listed in **Section 5B**, **Section 6K**, **Chapter 4, Chapter 5,** and **Chapter 13** are cause to reject an examinee for flying training (all classes), or continued flying duty (classes II or III) unless a waiver is granted. **Section 6G** applies to rated pilots **Section 6H** applies to FCIIU. Acute medical problems, injuries, or their appropriate therapy are cause for withholding certification for flying training, or temporarily restricting the individual from flying until the problem is resolved, using AF Form 1042 IAW **Section 6C.** 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. Consult aircrew waiver guide for waiverable conditions and waiver requirements.

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.

6.2.1.2. Pose minimal potential for subtle performance decrement, particularly with regard to the higher senses.

6.2.1.3. Be resolved, or be stable, and be expected to remain so under the stresses of the aviation environment.

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.

6.2.1.5. Cannot require exotic tests, regular invasive procedures, or frequent absences to monitor for stability or progression.

6.2.1.6. Must be compatible with the performance of sustained flying operations.

6.3. Waiver of Medical Conditions. The individuals and organizations with authority to grant a waiver for medically disqualifying defects are listed in **Attachment 2**. Controversial or questionable cases, and cases that fall outside of the parameters set by this instruction, will be referred to AFMSA/SG3PF at the discretion of the MAJCOMs.

6.3.1. **Initiating Waivers.** Forward all relevant medical information through AIMWTS to the waiver authority. Special requirements for flying waivers are contained in paragraph **6.2**

6.3.2. **Term of Validity of Waivers.**

6.3.2.1. The waiver authority establishes the term of validity of waivers.

6.3.2.2. An expiration date is placed on a waiver for any conditions that may progress or require periodic reevaluation.

6.3.2.3. Waivers are valid for the specified condition. Any exacerbation of the condition, or other changes in the patient's medical status, automatically invalidates the waiver, and they are placed Duties Not Involving Flying (DNIF) until the medical evaluation is complete, and a new waiver is requested.

6.3.2.4. If a condition resolves and member is qualified by appropriate standards, or the condition no longer requires a medical waiver, and individual has no other conditions requiring medical waiver, retire the waiver using AIMWTS with concurrence of waiver granting authority. 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.

6.4. AFMSA/SG3PF retains waiver authority as follows:

6.4.1. All initial categorical flying waivers; changes from one category to another; removal of a categorical restriction. **Note**: Consult **Attachment 2** for delegation of waiver authority to MAJCOM/ SG.

6.4.1.1. All FCIIU personnel certification and waiver unless otherwise delegated by AFMSA/SG3PF.

6.4.2. All initial waivers in cases previously certified medically disqualified by AFMSA/SG3P or MAJCOM/SG (rated).

6.4.3. All initial waivers for conditions listed in **Chapter 5**, Continued Military Service (Retention Standards).

6.4.4. All initial waivers for conditions referred to the ACS (Aeromedical Consultation Service), except for those as listed at **Attachment 2, Note 3**. **Exception:** MAJCOM/SG may grant initial and may renew waivers, 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.

6.4.4.1. MAJCOM/SGs will not grant/renew waivers for members of active ACS study groups without consulting the ACS.

6.4.5. All cases where the ACS recommends medical disqualification in accordance with **Attachment 2**.

6.4.6. All initial waivers for maintenance medication, except those listed in "Official Air Force Approved Aircrew Medications", updated periodically by AFMSA (approved by AF/SG3P).

6.4.7. All flying waivers and disqualifications on general officers, regardless of diagnosis.

6.4.8. All initial categorical IIC waivers except as delegated to MAJCOM/SG, see **Attachment 2, Notes**.

6.4.9. Renewal of IIC waivers originally granted by AFMSA/SG3P, except as delegated to MAJCOM/SG, see **Attachment 2, Notes.**

6.4.10. Any controversial condition that in the opinion of the MAJCOM/SG warrants an AFMSA/SG3P decision.

6.4.11. AFMSA retains certification/waiver authority for all color vision deficiencies.

6.4.12. Immunodeficiency syndromes, primary or acquired. Confirmed presence of HIV or antibody. AFMSA/SG3P retains waiver authority for all flying classes. See aircrew waiver guide.

6.4.13. Second waiver requests are considered on a case-by-case basis only, and waiver authority for these individuals is AFMSA/SG3P.

6.4.14. 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.

6.4.15. All FCIII depth perception deficiencies, color vision deficiencies, or other conditions that restrict the individual's ability to perform scanning duties or otherwise restrict ability to perform FCIII duties. **Note:** Enlisted flying criteria is the decision of the AFSC CFM at AF/A3.

6.4.16. All FCIIU waivers.

6.4.17. AFMSA/SG3PF may delegate waiver authority to MAJCOM on repeat categorical or other waivers for stable, long established conditions at its discretion on a case by case basis.

6.5. Delegation of Waiver Authority for Flying and Special Operational Duty (SOD) Personnel:

6.5.1. Command surgeons may delegate waiver authority to another command surgeon or to a Residency Trained Aerospace Medicine specialist working on that MAJCOM staff (RAM, AFSC 48A3/48A4 or ARC 48R3/48R4). Exceptions will be approved by AFMSA/SG3P. Command surgeons may delegate base level (local) waiver authority to the installation SGP. Waiver delegation will indicate authority based on residency trained Aerospace Medicine specialist (RAM) 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 members MAJCOM/SG of assignment with the exception of IFCIIU.

6.5.2. Certification and waiver authority for assignment into ARC flying positions may not be delegated lower than MAJCOM/SG level unless authorized by ARC/SG.

6.5.3. Certification and waiver authority for 9C aircrew is listed in **Attachment 2**.

6.6. Centralized Flying Waiver Repository (AIMWTS).

6.6.1. AIMWTS will serve as the centralized flying waiver repository.

6.6.2. All flying medical waiver actions will be recorded in AIMWTS.

6.6.3. Flying waivers that are no longer required due to personnel separation and/or retirement must be "retired" in AIMWTS.

6.7. Waivers for Enlisted Occupations.

6.7.1. The medical service does not make recommendations for medical waivers for entry or retention in non-flying or special operations duty AFSCs for those who fall below qualification standards imposed by personnel directives. Any flying or special operational restrictions/limitations must comply with 6.4.15. 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.

6.7.2. When requested, the medical service provides professional opinion to line or personnel authorities.

6.8. Submission of Reports of Medical Examination to Certification or Waiver Authority.

6.8.1. Waiver for Flying or Special Operational Duty.

6.8.2. Waiver requests for all initial flying and SOD examinations will be submitted using AIMWTS and PEPP. Supporting documents must be uploaded as attachments into these applications as listed in paragraph **6.8.3** and forwarded to the reviewing/certification authority. **Note:** PHA**,** SF 600, *Medical Record – Chronological Record of Medical Care*, SF 88 or DD Form 2808 must be accomplished according to the frequency in AFI 44-170 and is irrespective of waiver action. However, this document is not required for waiver submission for trained aviators unless specifically requested by the waiver authority. Utilize the aeromedical summary format when requesting waivers for trained aircrew or for aircrew in training. Do not accomplish SF 88, DD Form 2808, or PHA solely for the purpose of a waiver submission unless flight surgeon deems necessary, or directed by other authority.

6.8.3. All waiver requests referred to AFMSA/SG3P must be submitted through the MAJCOM/SG. MAJCOM/SG must provide a recommendation on the case to AFMSA/SG3P through AIMWTS. These requests must include as a minimum:

6.8.3.1. Aeromedical Summary with other supporting documents pertinent to the case included as attachments within AIMWTS as per the waiver guide.

6.8.3.2. If available, include the results of DPAMM abjudication, indicating the member has been returned to duty following ALC fast track or MEB/ Physical Evaluation Board (PEB).

6.8.3.3. AF Form 1139, *Request for Tumor Board Appraisal and Recommendation***,** if appropriate. Document the frequency and nature of required follow-up studies. A new tumor board is not required for waiver renewal if adequate documentation of follow-up, 5-year survival rate, and future follow-up requirements are included in the aeromedical summary.

6.8.3.4. SF 515, *Medical Record-Tissue Examination*, in cases of malignancy (initial waiver request).

6.8.4. The following are required for ARC:

6.8.4.1. Aeromedical Summary. This must be the AMS accomplished in AIMWTS.

6.8.4.2. AFIP (Armed Forces Institute of Pathology) opinion in cases of malignancy (initial waiver request).

6.8.4.3. Any other relevant documentation.

6.8.4.4. Civilian medical documentation. Medical documentation from the member's civilian health care provider will be included in all waiver cases submitted on ARC members. The examining flight surgeon will review this information and reference it in the aeromedical summary.

6.8.5. **Routing of Dispositions:**

6.8.5.1. The certifying authority certifies the AMS in AIMWTS.

6.8.5.1.1. Trained Assets: Flight Medicine prints and files the certified AMS document in the health record; then prepares, files, and forwards the AF Form 1042.

6.8.5.1.2. Initial flying waivers: Public Health (Flight Medicine for the ARC) prints and files the certified AMS document in the health record. Provides initial medical examinations for UPT, UNT, and AMP course training to the applicant to include with the training request. AMP course attendees must hand carry AF Form 1042 to USAFSAM.

6.8.5.1.3. MAJCOM/SGPA notifies AFMSA/SG3PF of disqualifications on rated pilots.

6.8.5.1.4. If certified disqualified (trained asset): A flight surgeon will advise the member they are medically disqualified from their flying or special operational duty, and provide the member with the AF Form 422, for use in retraining actions with the Military Personnel Flight. Document the notification of disqualification in the health record. The member's unit must also be notified of the member's disqualification from special operational duty. The AF Form 1042 may be used, with appropriate comments in the remarks section of the AF Form 1042 of the member's permanent disqualification from special operational duty.

6.8.5.2. Repatriated Prisoners of War (RPW). Public Health sends a copy of each medical examination (SF 88/DD Form 2808, SF 93/DD Form 2807-1, or DD Form 2697 and attachments) to USAFSAM/AFC, 2507 Kennedy Circle, Brooks City Base TX 78235-5116, 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

6.9. Applicability. Applies to each Air Force MTF or ARC medical squadron/Group providing support for flying or special operational duty personnel. Use AF Form 1042 to convey updates

and changes to medical qualification for flying or special operational duty. Flying or special operational duty 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, 6J,** and **6K**.

6.10. Authority to determine aeromedical dispositions. Non-flight surgeon medical providers may ground flying or special operational duty personnel. The flight surgeon must document review and disposition of all non-flight surgeon medical providers' entries in the member's medical record. A grounding AF Form 1042 initiated by a non-flight surgeon medical provider must be reviewed, countersigned and dated by the flight surgeon. Only a flight surgeon can return flying/special duty personnel to flying/duty status. Personnel on flying or special operational duty status who receive dental treatment will be managed IAW AFI 47-101, *Managing Air Force Dental Services.* Dental personnel will utilize AF Form 1418 to notify the flight surgeon of recommended flying or special duty restrictions. The reviewing flight surgeon should then initiate a DNIF via AF Form 1042. See AFI 47-101, Paragraph 6.16. for further details.

6.10.1. Aeromedical Disposition of ARC Personnel On Air Sovereignty Alert (ASA) or Federal RPA missions. ARC aviation personnel performing Air Sovereignty Alert (ASA) or operating large RPA systems in support of a Federal mission are eligible for active duty 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.

6.10.1.1. If a flight surgeon is not co-located with the ASA/RPA 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. The flight surgeon may render a DNIF or RTFS 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. All relevant medical and medication standards still apply. Aeromedical disposition decision must be communicated immediately to the aircrew's unit. The 1042 must be sent electronically to the aircrew's unit the morning of the next duty day.

6.10.1.1.1. Aircrew and special duty personnel in locations not collocated with an active duty 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/Special Operations Duty status after being examined by a military or civilian physician via "reach-back" consultation with a military Flight Surgeon as designated by AFMSA/SGPF.

6.10.2. Air National Guard (ANG) or Air Force Reserve Command (AFRC) Flight Surgeons who maintain active credentials and privileges in Flight Medicine may utilize their Flight Medicine credentials to make aeromedical dispositions while employed in a civilian Flight Medicine physician role.

6.11. Prepare a new AF Form 1042 when an individual is:

6.11.1. Found temporarily medically unfit—described as DNIF, Duties Not to Include Controlling (DNIC) or Duties Not to Include Alert (DNIA).

6.11.2. Determined by a flight surgeon to be fit for return to flying status (RTFS) or special operational duty.

6.11.3. Medically certified for flying by appropriate review authority following disqualification.

6.11.4. Medically certified for continued flying/special operational duty following medical examinations.

6.11.5. Medically certified by flight surgeon for Incoming Clearance to a new base. This new clearance will supersede any previous incoming clearances that must be removed from the record at this time.

6.11.6. To temporarily "ground" or clear aircrew following involvement in any class of aircraft mishap.

6.11.7. To permanently medically disqualify a member for flying or special operational duty.

6.11.7.1. 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 **6.1.3.1.4.2**. **Note:** An AF Form 1042 does not need to be accomplished with the expiration of a flying PHA. The Host Aviation Resource Management Office (HARM) Office will take appropriate administrative action if a new AF Form 1042 is not received by the end of the member's birth month.

6.12. Form Completion:

6.12.1. AF Form 1042 must contain the date the individual is actually found certified.

6.12.2. Date of the flight surgeon signature will serve as the date the action was accomplished.

6.12.3. 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/SGP using AIMWTS. If granted, a new AF Form 1042 must be accomplished to reflect the extension and sent to the member's HARM Office as specified in this chapter.

6.12.4. Flyers and special operational duty personnel unavailable for PHA secondary to deployment will follow guidance in AFI 44-170.

6.12.5. The remarks section of the AF Form 1042 can be used for local special purpose determinations, i.e., "May perform Supervisor of Flying (SOF) duties," with the determination based upon the flight surgeon's assessment of the member's mental alertness and physical capabilities. The Remarks section of any AF Form 1042 leaving the MTF will not have member's diagnosis or other protected health care information written or otherwise affixed in accordance with HIPAA rules. Commanders must be advised to contact the flight surgeons office if more details about a member's condition are required.

6.13. Inactive Flyers. Do not complete an AF Form 1042 for individuals in inactive aviation service categories who are not involved in flying duties, if the medical condition is minor, does not require a medical waiver, and is expected to resolve within 30 days. Inactive flyers with ASCs of 6J, 7J, 8J, or 9J (refer to AFI 11-401, Aviation Management) do not require aeromedical disposition (DNIF) for short term illnesses but must meet retention standards in Chapter 5. Flyers that develop disqualifying conditions while in inactive status require waiver or disqualification at the time of diagnosis, despite inactive status. **Note**: Inactive flyers need to be evaluated at each PHA for continued qualification to fly.

6.14. AF Form 1042 Distribution:

6.14.1. Original to patient's health record. For transient personnel, send the original and 2 copies to the individual's home Medical Treatment Facility Flight Surgeons Office for distribution.

6.14.2. Grounding management communications with operational units and HARM offices must be treated as Protected Health Information. Release of this information to operational units, commanders and HARM offices is allowed under DoD 6025.18-R, *DoD Health Information Privacy Regulation*, paragraph C7.11.1.1., but such releases of PHI must be documented IAW paragraphs C1.2.5. and C13.1.

6.14.2.1. The PIMR database is currently installed with a HIPAA-compliant documentation log for any releases of PHI sent via email notification from within PIMR. All such actions automatically generate an electronic log entry to document each release of PHI. This functionality includes e-mail notification to operational flying/special operational duty units and HARM offices regarding AF Form 1042 grounding management actions.

6.14.2.2. In addition to email notifications, a signed copy of the AF Form 1042 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 PIMR 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."

6.14.2.3. One copy to the local HARM Office (within 1 duty day) for flying personnel, or to the unit commander or supervisor for other personnel utilizing the HIPAA compliant documentation log within the e-mail notification the grounding management module.

6.14.2.4. 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.

6.14.2.5. One copy to the member.

6.14.2.6. 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.

6.15. Disposition of Expired AF Form 1042:

6.15.1. Grounding actions such as DNIF, DNIC, DNIA, dispose of when superseded by an AF Form 1042 for RTFS action.

6.15.2. Remove previous Initial Base clearances when superseded by a new Initial Base clearance AF Form 1042. Do not remove last PHA clearance on completing a newly assigned member's Initial Base clearance.

6.15.3. Remove previous PHA clearances when superseded by a new PHA clearance AF Form 1042. Do not remove last Initial Base clearance on completing a PHA clearance.

6.15.4. Do not remove AF Form 1042 recording a member's RTFS following a period of DNIF from the outpatient medical record. These must remain a permanent part of a member's medical record.

6.16. 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 Preventive Health Assessment and Individual Medical Readiness (PIMR) see AFI 48-101.

6.17. General Officer Notification. The flight medicine PCM will notify their MAJCOM/SG by telephone during duty hours when a general officer or wing commander is grounded or when an aircrew or special operational duty member dies. 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. **Note:** ANG does not require notification of the grounding of General Officers or Wing Commanders.

Section 6D—Aeromedical Consultation Service

6.18. General. The ACS Conducts Specialized Aeromedical Evaluations.

6.19. Eligibility Requirements. Persons eligible for referral to ACS include:

6.19.1. Active Duty Air Force and ARC personnel on flying status, or as requested by the MAJCOM/SG or AFMSA/SG3P. Persons medically disqualified when approved by the MAJCOM/SG or AFMSA/SG3P.

6.19.2. Members of active ACS clinical management groups not on flying status (inactive flyers and disqualified members).

6.19.3. 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).

6.19.4. At the discretion of the MAJCOM/SG or AFMSA/SG3P, initial ACS evaluations of inactive flyers only if reassignment to active flying is pending.

6.19.5. Army and Navy personnel with approval of U.S. Army Aeromedical Center (USAAMC) Fort Rucker, AL, or NOMI, Pensacola, FL.

6.19.6. Military personnel of foreign countries when approved by the State Department and AFMSA/SG3P.

6.19.7. Applicants for flying duty with approval by HQ AETC/SG or AFMSA/SG3P.

6.19.8. Under special circumstances, astronauts may be given Secretarial Designee Status for ACS evaluation.

6.20. Referral Procedures.

6.20.1. Initial Evaluations: The referring flight surgeon prepares an aeromedical summary utilizing the AIMWTS program. Once ACS evaluation is approved by either MAJCOM/SGPA or AFMSA/SG3PF, MTFs will send original records of special studies mentioned in the aeromedical summary. i.e., Electrocardiogram (ECG) tracings, echocardiogram tape, Electroencephalogram (EEG) tracings, Holter monitor tracings, MRI film, all x-ray films and specialty consultations, etc., to the ACS electronically, or by certified mail (whichever is appropriate and feasible). **Note:** The appropriate mailing address is: USAFSAM/FECA, 2507 Kennedy Circle, Brooks City-Base TX 78235-5116.

6.20.2. 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.

6.21. Scheduling Procedures.

6.21.1. The approval authority will forward the request to the ACS utilizing AIMWTS.

6.21.2. 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 waiver authority 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.

6.21.3. Members scheduled for ACS evaluations will be briefed by the referring local flight surgeon regarding ACS requirements and reporting instructions. This responsibility will not be delegated.

6.21.4. 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).

6.21.5. The orders state that the TDY is for aeromedical evaluation and that 10 days, in addition to travel time, is authorized. Orders must direct travel to ACS by the most expeditious means possible.

6.21.6. Send health records, by certified mail to arrive at the ACS 10 days before the scheduled appointment. A hand carried copy of the medical record is acceptable only in its entirety.

6.22. Consultation Procedures.

6.22.1. The ACS evaluates and makes recommendations to the waiver authority. The ACS is not a waiver authority.

6.22.2. The preliminary ACS report and recommendation called the Patient Status Worksheet (PSW) 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.

6.22.3. If an in-person ACS evaluation is not required, the ACS will make recommendations via an aeromedical letter to the waiver authority. The ACS enters this into AIMWTS.

6.22.4. The final ACS report and recommendation called the 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

6.23. Medical Flight Screening.

6.23.1. MFS is managed by the ACS and conducted at two sites: the ACS and the USAFA.

6.23.2. 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 and FCIIU applicants must complete and successfully pass MFS or receive a waiver prior to starting UPT or RPA Pilot training.

Section 6F—USAF Aircrew Corrective Lenses

6.24. 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 this section. This section describes USAF policy for routine contact lens use under the USAF Aircrew Soft Contact Lens (ACSCL) Program and for specialized contact lens authorized by an aeromedical waiver.

6.25. Routine contact lens use by USAF aircrew is authorized, without an aeromedical waiver, provided program requirements are met and maintained. Only USAF approved soft contact lenses (SCLs) and related solutions are authorized for routine aircrew contact lens use by ACSCL eligible aircrew. A list of approved SCLs and related solutions is available online: "ACSCL_Approved_SCL_SOLUTIONS" at Air Force Knowledge Exchange (KX): **https://kx.afms.mil/usaf_contact_lens**.

6.26. Specialized contact lens use by USAF aircrew must be authorized by an aeromedical waiver (see 6.37.). Specialized contact lens use includes; medical conditions that require contact lens use to meet USAF aviation vision standards, use of contact lenses other than USAF approved contact lenses (ACSCL_Approved_SCL_Solutions), and/or refractive errors exceeding program limits.

6.27. ACSCL Eligibility. Adherence to this policy is required by:

6.27.1. Flying Class I/IA electing to wear contact lenses, on or off duty (see **6.29**).

6.27.2. Flying Class II and IIU electing to wear contact lenses, on or off duty.

6.27.3. Flying Class III if they use contact lenses for in-flight duties. Note: Flying Class III electing to wear contact lenses, but not while performing flying duties, are NOT required to follow the USAF Aircrew SCL policy, but are highly encouraged to do so. Personnel who

are receiving flight pay and are required to perform their duties while on aircraft must comply with the SCL program.

6.27.4. USAF contracted DoD civilian aviators and flight instructors electing to wear SCL, on or off duty, may use any FDA approved SCL, but must provide documentation of efficacy of fit to the local Flight Surgeon's Office (FSO). This must include documentation of at least 20/20 vision in each eye with current spectacles immediately after removing SCL, and in each eye while wearing SCL for both near and distant vision. SCL monovision (one eye corrected to near vision) correction is specifically prohibited. Bifocal spectacles used in combination with SCL to correct near vision to 20/20 are permitted (see **6.34**)

6.28. ACSCL: Program Administration/Funding.

6.28.1. Administration of the SCL program is the responsibility of the local FSO.

6.28.2. Active Duty Flying Class II and IIU will receive fitting, prescription, and follow-up at local MTF.

6.28.3. ARC Class II and IIU may receive fitting, prescription, and follow-up at local ARC Medical Treatment Facility if an eye specialist is assigned. If this capability does not exist at MTF, fitting, prescription, and follow-up will be provided by a civilian eye care professional. SCL policy requirements must be met. **Note:** ANG members are responsible for costs incurred with civilian eye care, SCL, and related solutions.

6.28.4. Active Duty Flying Class III who wear SCL while performing flying duties will receive fitting, prescription, and follow-up at local MTF if the MAJCOM/SG agrees that capability exists within the MTF, and flying squadron commander determines operational justification exists.

6.28.5. ARC Flying Class III may receive fitting, prescription, and follow-up at local MTF if an eye specialist is assigned, and flying squadron commander determines operational justification exists. If this capability does not exist at MTF, fitting, prescription, and follow-up will be provided by a civilian eye care professional. SCL policy requirements must be met. **Note:** ANG members are responsible for costs incurred by a civilian eye care professional.

6.28.6. Flying squadron commander will purchase SCL and supplies with unit funds for Class II, IIU and/or III, if operational justification to fly with SCL exists.

6.28.7. UFT members are not authorized funding for SCLs and related supplies.

6.29. ACSCL: UFT Entry into USAF ACSCL Program. Flying Class I/IA applicants must satisfy the following conditions prior to use of SCLs during UFT and enrollment into the SCL program, in addition to requirements detailed in this section.

6.29.1. Only UFT applicants who have been wearing USAF approved SCL for at least six months prior to UFT, without difficulty, will be authorized to enter the USAF Aircrew SCL Program, and be allowed to wear SCL during UPT. The UFT applicant is responsible to provide civilian SCL documentation to the local FSO. The UFT applicant must be examined and processed by the local FSO and Optometry Clinic to determine adequacy of fit and visual function. Refitting SCL will NOT normally be accomplished during UFT unless operational or medically indicated.

6.29.2. UFT students entered into the USAF ACSCL Program are responsible for costs incurred with civilian eye care, SCLs and related solutions.

6.29.3. All UFT applicants are to cease wearing SCL for 30 days prior to their Initial Flying Class I/IA physical examination. UPT applicants must also cease wearing SCL for 30 days prior to the Medical Flight Screening physical examination**.** This is to overcome any temporary alteration in the cornea that may be caused by SCL wear.

6.30. ACSCL: Aircrew Responsibilities.

6.30.1. Aircrew requesting initial SCL fitting must visit local FSO for briefing and assessment.

6.30.2. Aircrew wearing contact lenses must report use and any complications to local FSO.

6.30.3. Aircrew will receive and be familiar with mandatory instructions for SCL use.

6.30.4. Maintaining the currency of SCL prescriptions.

6.30.5. Follow General Flight Rules (see AFI 11-202, Vol 3 Para 6.3.3) which states aircrew "who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties."

6.30.6. Ensure their primary and backup spectacles are current and adequate to meet aeromedical vision standards.

6.30.7. Maintain at least one set of unused and current replacement contact lenses. Aircrew on mobility must satisfy requirements listed in **6.36**.

6.30.8. Aircrew buying their own contact lenses and supplies are responsible to ensure these materials comply with the current AF approved list or have a current aeromedical waiver authorizing contact lenses not on the approved list.

6.31. ACSCL: Flight Surgeon Responsibilities.

6.31.1. Administrate the USAF Aircrew SCL Program. Document and manage contact lens use by all eligible aircrew members as defined by this section.

6.31.2. Brief USAF aircrew and ensure they are familiar with the contents of "USAF Aircrew Soft Contact Lens (SCL) Program."

6.31.3. Ensure all contact lens related operational incidents, medical complications, and DNIF days are reported to USAFSAM/FECO.

6.32. ACSCL: Optometry Clinic Responsibilities.

6.32.1. Examine, fit and prescribe SCL for all active duty Flying Class II, IIU and all other active duty aircrew identified by flying squadron commander, including ARC aircrew authorized to wear SCL in-flight and who have access to a unit eye clinic (see **6.28.5**).

6.32.2. Report all aircrew contact lens related incidents and complications to local FSO and USAFSAM/FECO in the format "USAF Aircrew Contact Lens Incident Report" Incident Report Form. Incident form and USAFSAM/FECO contact info available on: **https://kx.afms.mil/usaf_contact_lens**.

6.32.3. Obtain the current "USAF Approved SCL and Related Solution" list available online in the Air Force KX: **https://kx.afms.mil/usaf_contact_lens**.

6.32.4. Train aircrew in the emergency removal of SCL.

6.33. ACSCL: Aeromedical Requirements for USAF Aircrew SCL Wear. No history of 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 require an aeromedical waiver (see **6.37**).

6.33.1. Visual acuities of 20/20 or better in each eye with current spectacles for both near and distant vision, immediately after removing SCL.

6.33.2. 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 (see **6.34.4-5**).

6.33.3. 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 authorizing Aeromedical waiver.

6.34. ACSCL: Special Considerations. All Aircrew must note that:

6.34.1. Only SCLs and related solutions identified on the"ACSCL_Approved_SCL_SOLUTIONS" list are authorized for use. The "ACSCL_Approved SCL_Solutions" list is reviewed and updated by USAFSAM/FECO annually. The current list is available online in the Air Force KX: **https://kx.afms.mil/usaf_contact_lens**.

6.34.2. Use of any Use of any SCLs, Hard/Rigid Gas Permeable Lenses (HCL/RGP), and/or related solutions not specifically authorized on the "ACSCL_Approved_SCL_SOLUTIONS" list are NOT permitted without an aeromedical waiver for any eligible aircrew (see **6.26** and **6.27**).

6.34.3. Aircrew who require prescriptions exceeding SCL program limits (i.e. high astigmatism) must obtain an aeromedical waiver authorizing use.

6.34.4. Monovision contact lens correction (one eye corrected to near vision) is NOT permitted while performing flight duties.

6.34.5. Bifocal, multifocal or varifocal SCL are NOT permitted.

6.34.6. The use of flat-top or double-D bifocal spectacles in combination with SCL for near correction is permitted, provided the distance portion is plano. Bifocal power may be adjusted for cockpit use (cockpit viewing distances may differ from routine clinical test distances). Progressive Addition (no line) bifocals are NOT permitted.

6.34.7. Wearing of spectacles (bifocal or single vision) in combination with SCL for distance correction is NOT permitted without an aeromedical waiver.

6.34.8. Use of generic or private labeled SCLs are NOT permitted.

6.35. ACSCL: Fitting, Follow-Up and Wear Schedule.

6.35.1. ACSCL Examination (must be documented in medical records):

6.35.1.1. Slit lamp Examination with and without SCL.

6.35.1.2. SCL Visual Acuity of 20/20 or better at distant and near, as well as with spectacles immediately after removal of SCL.

6.35.1.3. Review of wear schedule compliance, handling/cleaning issues, and contact lens related solution requirements.

6.35.2. Initial ACSCL evaluations.

6.35.2.1. Following initial contact lens issue - Seven days, One and Six months (with eye care provider) **Note:** During the first seven days of wear, aircrew must not wear SCL in flight or within eight hours prior take-off.

6.35.3. Experienced (greater than 6 months of uncomplicated contact lens wear) ACSCL evaluations.

6.35.3.1. Annually, prior to flight physical.

6.35.4. Contact lenses must never be worn during sleep, or for more than 24 consecutive hours, unless operationally required.

6.36. ACSCL: Mobility Requirements for contact lens wear.

6.36.1. Deploying aircrew are required to carry the following (unless prohibited by AOR policy):

6.36.1.1. One factory sealed replacement set of contact lenses, if wearing non-disposable contact lenses (matching current contact lens prescription).

6.36.1.2. Three month supply of factory sealed replacement SCL, if wearing disposable or frequent replacement SCL (matching current contact lens prescription).

6.36.1.3. Sufficient, current SCL solutions for initial deployment (one month supply).

6.36.1.4. Two pair of clear and two pair of sunglass spectacles, with current prescription lenses (see **6.39.3**)

6.36.2. Aircrew flight equipment retains responsibility to maintain USAF approved SCL solutions for deployment.

6.37. ACSCL: Aeromedical Waivers. Aircrew required to wear contact lenses outside the scope of the USAF ACSCL Program must obtain an aeromedical waiver after review or evaluation by the Aeromedical Consultation Service (USAFSAM/FECO).

6.37.1. Aeromedical summary is submitted to MAJCOM/SG.

6.37.2. Aeromedical waiver review by the Aeromedical Consultation Service (USAFSAM/FECO).

6.38. Authorized Spectacle Frames for USAF Aircrew (USAF Aircrew Spectacle Frame Program and AFI-11-202 vol 3: General Flight rules).

6.38.1. USAF aircrew and 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.

6.38.2. 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), 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. These modifications were implemented to meet the integration requirements of the new tri-service chem/bio protective ensemble called the Joint Service Aircrew Mask (JSAM); the current helmet mounted targeting system known as the Joint Helmet Mounted Cueing System (JHMCS); and the new Joint Strike Fighter (JSF) advanced helmet/mask ensemble.

6.39. Prescription Eyewear:

6.39.1. Local base optometry office is responsible for coordinating (prescribing, ordering, fitting, as required) spectacle-based vision correction for USAF aircrew.

6.39.2. 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. No other sun protection tint or spectacle frame is authorized for use in USAF aircraft by USAF aircrew or USAF contracted aircrew. The eye clinic orders the required sets through the DoD Optical Fabrication Enterprise in the same manner as other military eyewear orders through SRTS Legacy. Eye clinics may also order AFF replacement parts (nose pads, temple screws, temples, etc) using unit funds through the Electronic Catalog (ECAT) at **https://medweb.dscp.dla.mil/pls/prod/logon**.

6.39.3. Aircrew requiring prescription eyewear are authorized two sets of clear and two sets of sun protection eyewear (four pairs of spectacles) for flight duties.

6.39.4. If required for mobility, gas mask inserts are authorized for non-flight duties.

6.40. Non-Prescription Eyewear:

6.40.1. Non-prescription AFF sun protection is obtained through local Individual Equipment Issue (IEI) or equivalent supply office utilizing member's unit funds.

6.40.2. 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.

6.40.3. 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.

6.41. Aircrew Spectacles: other considerations:

6.41.1. Lens Requirements:

6.41.1.1. Fabrication Materials.

6.41.1.1.1. CR-39 plastic.

6.41.1.1.2. Crown Glass – 3.0mm minimum center thickness chemically hardened).

6.41.1.1.3. Polycarbonate, hi-index plastic .

6.41.1.1.4. Clear or neutral density (N-15 – gray) sunglass tint. Note: any tint, other than neutral density (N-15) gray, is not authorized for sun protection use.

6.41.1.1.5. Scratch resistant coatings for polycarbonate lenses.

6.41.2. NOT Authorized.

6.41.2.1. Polarized lenses.

6.41.2.2. Photochromic lenses.

6.41.2.3. Progressive addition (no line) bifocal lenses.

6.41.2.4. Commercially procured sunglasses.

6.42. Ballistic Eye Protection:

6.42.1. 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 (PEO Soldier) and found to meet or exceed military ballistic standards. BPE is authorized for ground use. Additional uses for specific BPE may be authorized for aircrew and be listed on the Flight Protective Eyewear List (FPEL). The AFF series frames are not equivalent to BPE. BPE (non-prescription spectacle/goggles) is obtained through local Aircrew Flight Equipment or equivalent supply office through the member's unit. Prescription inserts for the BPE are ordered by the local optometry clinic through the SRTS ordering program.

6.42.1.1. Current APEL and FPEL available on-line:

6.42.1.1.1. USAF Optometry Knowledge Junction / BPE: **https://www.kx.ams.mil/optometry**.

6.42.1.1.2. USAF Flight Medicine Knowledge Junction / BPE: **https://www.kx.ams.mil/flightmedicine**.

6.42.2. Aircrew BPE must be approved by the USAF Spectacle Frame Program (POC: USAFSAM/FECO). No other BPE is authorized for use by USAF aircrew or USAF contracted aircrew.

6.43. Laser Eye Protection (LEP): Prescription LEP Accessory Device Requirements.

6.43.1. Laser eye protection (LEP) devices are controlled items that protect aircrew from eye damage arising from laser threats. Laser eye protection devices are stored and maintained by Aircrew Flight Equipment. Prescription LEP accessory devices (typically an insert or outsert which attaches to the LEP) are available for most aircrew who require corrective lenses to meet vision standards. Not all LEP devices support refractive error correction.

6.43.2. Aircrew wearing LEP devices who require vision correction may do so by wearing contact lenses (see **6.24**) or application of a prescription accessory device.

6.43.3. Regardless of Aircrew Soft Contact Lens Program participation, prescription LEP accessory devices, when available, will be ordered for aircrew with refractive error in the event contact lens wear is not possible.

6.43.4. Laser eye protection device availability and designs vary by installation. The flight surgeon, in coordination with the ophthalmology/optometry clinics, will communicate

directly with Aircrew Flight Equipment to determine the prescription laser eye protection accessory device requirement for assigned aircrew.

6.43.5. The flight surgeon and ophthalmology/optometry clinics will ensure aircrew LEP prescription accessory devices, when available, meet individual corrective vision specifications and are properly fitted per AFI 11-301v4 (Aircrew Laser Eye Protection).

6.43.6. Prescription laser eye protection accessory devices are ordered through the Spectacle Request Transmission System (SRTS).

6.43.7. Coordinating References.

6.43.7.1. TAF 505-87-II-A Operational Requirements Document for Aircrew Laser Eye Protection.

6.43.7.2. AFI 11-301v4 Aircrew Laser Eye Protection (ALEP).

Section 6G— Medical Standards for Flying Duty

6.44. Medical Standards. For accessions and enlistments the standards in Chapter 4 apply. Chapter 5 applies to personnel already serving as active duty or ARC (example, AD SSgt applying for IFCI duty must meet retention standards in Chapter 5, as well as IFCI standards). For conditions listed in Chapter 5, ensure a MEB or assignment limitation code fast-track request has been initiated if appropriate. When a crewmember receives care by a non-flight surgeon provider, the member must be seen by a flight surgeon for appropriate aeromedical disposition prior to resuming flying duties. 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. **Note**: For medical standards for RPA pilot duties only, refer to Section H.

For flying class I, IA, II, IIU and III. Use of any medication is prohibited, except as described in the "Official Air Force Approved Aircrew Medication" updated periodically by AFMSA (approved by AF/SG3P). Use of any Over the Counter (OTC) Medications, except as described in the "Official Air Force Approved Aircrew Medications & Over the Counter (OTC) Medications", updated periodically by AFMSA (approved by AF/SG3P) is prohibited. All medications and immunizations used by flying and special operational duty personnel must be FDA approved. All FDA approved medications not listed in the "Official Air Force Approved Aircrew Medications & Over the Counter (OTC) Medications" lists should be assumed to be disqualifying for flying duty. The aviator may be returned to flying status after the condition has resolved, the medication has been discontinued, and its effects have dissipated, which usually entails on additional day (the "24 hour rule").

Acupuncture is permitted for aircrew, ground based controllers, SMOD and special duty personnel within the following guidelines: No flying/SOD with retained needles; no self–referrals (must have referral from flight surgeon and note in medical record); treatment must be done by DoD providers or civilian practitioners within DoD MTFs who are credentialed in acupuncture treatment; used for short-term treatments only. Acupuncture requires 12 hours post-treatment DNIF/DNIC and evaluation by flight surgeon prior to RTFS (no automatic RTFS) . Flight surgeons must consider the patient's underlying condition and whether or not the condition itself requires DNIF or waiver.

6.44.1. **Head, Face, Neck, and Scalp (Flying Classes I, IA, II, and III).**

6.44.1.1. Injuries to the head (see **6.44.23**.)

6.44.1.2. Loss or congenital absence of bony substance of the skull.

6.44.1.3. Chronic arthritis, complete or partial ankylosis, or recurrent dislocation of the temporomandibular joint.

6.44.1.4. Congenital cysts of branchial cleft origin or those developing from the remains of a thyroglossal duct, with or without fistulous tracts.

6.44.1.5. Chronic draining fistulae of the neck, regardless of cause.

6.44.1.6. Contractions of the muscles of the neck if persistent or chronic. Cicatricial contracture of the neck to the extent it interferes with function or the wear of equipment.

6.44.1.7. Cervical ribs if symptomatic or symptoms can be induced by abduction, scalenus, or costoclavicular maneuvers.

6.44.1.8. Any anatomic or functional anomaly of head or neck structures, which interfere with normal speech, ventilation of the middle ear, breathing, mastication, swallowing, or wear of aviation or other military equipment.

6.44.2. **Nose, Sinuses, Mouth, and Throat.**

6.44.2.1. **Flying Classes II and III.**

6.44.2.1.1. Allergic rhinitis, unless mild in degree, controlled by use of approved medications, and considered unlikely to limit the examinee's flying activities.

6.44.2.1.2. Chronic nonallergic or vasomotor rhinitis, unless mild, asymptomatic, and not associated with eustachian tube dysfunction.

6.44.2.1.3. Nasal polyps.

6.44.2.1.4. Deviations of the nasal septum, septal spurs, enlarged turbinates or other obstructions to nasal ventilation which result in clinical symptoms. Symptomatic atresia or stenosis of the choana.

6.44.2.1.5. Epistaxis, chronic, recurrent.

6.44.2.1.6. Chronic sinusitis unless mild in degree and considered unlikely to limit the examinee's flying activities.

6.44.2.1.7. Recurrent calculi of the salivary glands or ducts.

6.44.2.1.8. Deformities, injuries, or destructive diseases of the mouth (including teeth), nose, throat, pharynx, or larynx that interfere with ventilation of the paranasal sinuses and, or middle ear, breathing, easily understood speech, or mastication and swallowing of ordinary food.

6.44.2.1.9. Atrophic rhinitis.

6.44.2.1.10. Perforation of the nasal septum.

6.44.2.1.11. Anosmia or parosmia.

6.44.2.1.12. Salivary fistula.

6.44.2.1.13. Ulcerations, perforation, or extensive loss of substance of the hard or soft palate; extensive adhesions of the soft palate to the pharynx; or complete paralysis of the soft palate. Unilateral paralysis of the soft palate which does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying.

6.44.2.1.14. Chronic pharyngitis and nasopharyngitis.

6.44.2.1.15. Chronic laryngitis. Neoplasm, polyps, granuloma, or ulceration of the larynx.

6.44.2.1.15.1. Aphonia or history of recurrent aphonia, if the cause was such as to make subsequent attacks probable. Painful dysphonia plicae ventricularis.

6.44.2.1.15.2. Tracheostomy or tracheal fistula.

6.44.2.1.15.3. Malformations, injuries or diseases of the esophagus, such as ulceration, diverticulum, varices, stricture, achalasia, pronounced dilation, or peptic esophagitis.

6.44.2.1.16. History of sleep apnea or other clinical sleep disorders, regardless of prior treatment.

6.44.2.2. **Flying Classes I and IA. In addition to the above:**

6.44.2.2.1. A verified history of allergic, nonallergic, or vasomotor rhinitis, after age 12, unless symptoms are mild and can be controlled by a single approved medication.

6.44.2.2.2. Any surgical procedure for sinusitis, polyposis or hyperplastic tissue. See aircrew waiver guide.

6.44.3. **Ears.**

6.44.3.1. **Flying Classes II and III.**

6.44.3.1.1. History of surgery involving the middle ear, excluding cholesteatoma (See **6.44.3.1.9**).

6.44.3.1.2. History of mastoid surgery.

6.44.3.1.3. Inability to perform the valsalva maneuver.

6.44.3.1.4. Perforation of the tympanic membrane. Surgery to repair perforated tympanic membrane is disqualifying until healing is complete and hearing is normal.

6.44.3.1.5. Tinnitus when associated with active disease.

6.44.3.1.6. Abnormal labyrinthine function.

6.44.3.1.7. Recurrent episodes of vertigo with or without nausea, vomiting, tinnitus, and hearing loss.

6.44.3.1.8. Any conditions that interfere with the auditory or vestibular functions.

6.44.3.1.9. Cholesteatoma, or history of surgical removal of cholesteatoma.

6.44.3.1.10. Atresia, tuberosity, severe stenosis or tumors of the external auditory canal which prevents an adequate view of the tympanic membrane or effective therapeutic access to the entire external auditory canal.

6.44.3.2. **Classes I, IA, II (flight surgeon applicants) and III (initial applicants).** In addition to **6.44.3.1**

6.44.3.2.1. Applicants must demonstrate satisfactory performance of the Reading Aloud Test (RAT).

6.44.3.2.2. History of radical mastoidectomy.

6.44.3.2.3. History of abnormal labyrinthine function, unexplained or recurrent vertigo.

6.44.3.2.4. Surgical repair of perforated tympanic membrane within the last 120 calendar days.

6.44.4. **Hearing.**

6.44.4.1. **Flying Class II and III.** Hearing loss greater than H-1 profile, or asymmetric hearing loss, requires work-up by an audiologist (audiology evaluation for initial waiver and waiver renewals must have been accomplished within 12 months of submission to waiver authority). Waivers are required for H-3 hearing loss or greater. Indefinite waivers are not authorized.

6.44.4.1.1. For trained assets an H-2 profile alone does not require waiver. However, an evaluation sufficient to rule-out conductive or retrocochlear pathology must be conducted. This includes full audiologic evaluation and, where appropriate, referral for Ear, Nose, and Throat (ENT) consultation. Referral to ENT may be at the discretion of the audiologist or referring facility. Restriction from flying is not required during work-up.

6.44.4.1.2. H-3 profile requires waiver.

6.44.4.1.2.1. For members with new H-3 profiles (i.e., those whose hearing has recently changed to H-3, and who have not been previously worked-up), restriction from flying is appropriate. **Note**: Members with long-standing, stable H-3 not previously evaluated by an audiologist and/or ENT, require work-up and waiver, but need not be restricted from flying, unless in the opinion of the flight surgeon they represent a danger to flying safety.

6.44.4.1.2.2. Interim waiver may be granted by MAJCOM/SG after determination of acceptable hearing proficiency (occupational aircrew hearing assessment), pending complete audiology evaluation (indefinite waivers are not authorized).

6.44.4.1.2.3. For actively flying personnel, validate hearing proficiency in one of two ways prior to issuance of medical waiver for H-3 profile:

6.44.4.1.2.3.1. Inflight hearing test as described in SAM TR73-29, *Materials and Procedures for In-flight Assessment of Auditory Function in Aircrewmen* and reproduced in physical examination techniques.

6.44.4.1.2.3.2. Written validation, signed by the flying squadron commander or operations officer, of the adequacy of the member's hearing to perform safely in assigned aircrew duties in the flying environment. This validation must be supplemented by the assigned flight surgeon's written memorandum for record stating that speech discrimination levels, according to examination by audiologist, are adequate for the performance of flying duties.

6.44.4.1.2.4. Waiver is contingent upon complete audiologic and where appropriate, ENT evaluation. **Note**: The audiologist must rule out conductive and retrocochlear disease. The audiologist may defer ENT evaluation.

6.44.4.1.2.5. The occupational aircrew hearing assessment is deferred for inactive flyers. They may receive a Flying Class IIC waiver specifying the completion of the occupational aircrew hearing assessment before return to active flying. The pending requirement for operational hearing evaluation upon return to cockpit duties must be entered on the AF Form 1042.

6.44.4.2. Asymmetric hearing loss (greater than, or equal to, 25 decibel (dB) difference, comparing left and right ear, at any two consecutive frequencies) requires full audiological work-up with further clinical evaluation as indicated, and requires a waiver (indefinite waivers are not authorized). Restriction from flying is not required during work-up. Also, see aircrew waiver guide.

6.44.4.3. The following tests are suggested as a complete audiologic evaluation:

6.44.4.3.1. Pure tone air and bone conduction thresholds.

6.44.4.3.2. Speech reception thresholds.

6.44.4.3.3. Speech discrimination testing, to include high intensity discrimination.

6.44.4.3.4. Immittance audiometry.

6.44.4.3.5. Tympanograms.

6.44.4.3.6. Ipsilateral and contralateral acoustic reflexes (levels not exceeding 110 dB HL).

6.44.4.3.7. Acoustic reflex decay (500 and 1000 Hz, with levels not exceeding 110 dB HL).

6.44.4.3.8. Otoacoustic emissions (transient evoked or distortion product).

6.44.4.4. The following tests may be required if indicated by those listed in **6.44.4.3**

6.44.4.4.1. Auditory brainstem response.

6.44.4.4.2. MRI. **Note**: Validation of hearing proficiency for H-3 waivers (initial waivers and waiver renewals with a shift of 10 dB or greater on the average for 2,000, 3,000 and 4,000 Hz from the previous waiver's audiogram.

6.44.4.5. Initial Flying Class FCI/IA, II and III must be H1 for selection.

6.44.5. **Dental.**

6.44.5.1. Flying Classes II and III.

6.44.5.1.1. Personnel wearing orthodontic appliances need not have appliances removed for physical qualification. After consultation with the treating orthodontist, the local flight surgeon may qualify the individual for flying duties if there is no effect on speech or the ability to wear equipment with comfort.

6.44.5.1.2. Severe malocclusion (524) which interferes with normal mastication or requires protracted treatment.

6.44.5.1.3. Diseases of the jaw or associated structures such as cysts, tumors, chronic infections, and severe periodontal conditions which could interfere with normal mastication, until adequately treated.

6.44.5.1.4. Aircrew members who have a significant dental defect which may be expected to cause a dental emergency during flight will be grounded. ARC members are managed IAW **11.14**

6.44.5.2. Classes I and IA. In addition to those listed at **6.44.5.1** to **6.44.5.1.4**

6.44.5.2.1. Dental defects such as carious teeth, malformed teeth, defective restorations, or defective prosthesis, until corrected.

6.44.5.2.2. Anticipated or ongoing treatment with fixed orthodontic appliances.

6.44.6. **Eye, Flying Classes I, IA, II, and III.**

6.44.6.1. Lids/Adnexa.

6.44.6.1.1. Any condition of the eyelids which impairs normal eyelid function or comfort, or potentially threatens visual performance.

6.44.6.1.2. Epiphora, nasolacrimal duct obstruction.

6.44.6.1.3. Ptosis, any, except benign etiologies which are not progressive and do not interfere with vision in any field of gaze or direction.

6.44.6.1.4. Dacryocystitis, acute or chronic.

6.44.6.1.4.1. Dacryostenosis.

6.44.6.2. Conjunctiva.

6.44.6.2.1. Conjunctivitis, chronic, allergic.

6.44.6.2.2. Trachoma, unless healed without visually significant scarring.

6.44.6.2.3. Xerophthalmia.

6.44.6.3. Cornea.

6.44.6.3.1. Keratitis, chronic or acute, if the condition is recurrent, requires prolonged treatment, or leads to opacification or other sequelae that interferes with vision.

6.44.6.3.2. Corneal ulcers or recurrent corneal erosions.

6.44.6.3.4. History of traumatic corneal laceration unless it does not interfere with vision, nor is likely to progress.

6.44.6.3.5. Corneal dystrophy of any type, including keratoconus of any degree and topographical pattern suggestive of keratoconus (TPSK).

6.44.6.3.6. History of refractive surgery of any type, to include radial keratotomy (RK) or any other surgical or laser procedures, intraocular lenses, or corneal implants (INTACS), accomplished to modify the refractive power of the cornea or for any other reason, such as phototherapeutic keratectomy (PTK). Waiver criteria are listed in the corresponding aircrew waiver guide.

6.44.6.3.7. Corneal refractive therapy (CRT) active or a history of these procedures.

6.44.6.3.8. Lamellar or penetrating keratoplasty (corneal transplant).

6.44.6.4. Uveal Tract. Acute, chronic or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid), except for healed traumatic iritis.

6.44.6.5. Retina/Vitreous.

6.44.6.5.1. Retinal detachment and history of same.

6.44.6.5.2. Degenerations, scarring, and dystrophies of the retina, including lattice degeneration, retinoschisis and all types of central and peripheral pigmentary degenerations.

6.44.6.5.3. Degenerations and dystrophies of the macula, macular cysts, and holes.

6.44.6.5.4. Retinitis, chorioretinitis, or other inflammatory conditions of the retina, unless single episode which has healed, produced stable scarring, <u>and</u> is expected not to recur or progress, <u>and</u> does not impair central or peripheral vision.

6.44.6.5.5. Angiomatoses, phakomatoses, retinal cysts and other conditions which impair or may impair vision.

6.44.6.5.6. Hemorrhages, exudates or other retinal vascular disturbances.

6.44.6.5.7. Vitreous opacities or disturbances which may cause loss of visual acuity.

6.44.6.6. Optic Nerve.

6.44.6.6.1. Congenito-hereditary conditions that interfere or may interfere with central or peripheral vision.

6.44.6.6.2. Optic neuritis, of any kind, including retrobulbar neuritis, papillitis, neuroretinitis, or a documented history of same.

6.44.6.6.3. Papilledema.

6.44.6.6.4. Opticatrophy (primary or secondary) or optic pallor.

6.44.6.6.5. Optic nerve cupping greater than 0.4 or an asymmetry between the cups of greater than 0.2, unless proven to be physiologic after comprehensive evaluation by an eyecare specialist. This evaluation must include local diurnal pressure checks and visual field testing.

6.44.6.6.6. Optic neuropathy.

6.44.6.6.7. Optic nerve head drusen.

6.44.6.7. Lens.

6.44.6.7.1. Dislocation of a lens, partial or complete.

6.44.6.7.2. Opacities, cataracts, or irregularities of the lens, which interfere with vision, or are considered to be progressive.

6.44.6.7.3. Pseudophakia (intraocular lens implant).

6.44.6.7.4. Posterior and/or anterior capsular opacification.

6.44.6.7.5. Intraocular contact lenses.

6.44.6.8. Other Defects and Disorders.

6.44.6.8.1. Asthenopia, if severe.

6.44.6.8.2. Exophthalmos, unilateral or bilateral.

6.44.6.8.3. Nystagmus of any type, except on versional end points.

6.44.6.8.4. Diplopia in any field of gaze, either constant or intermittent, including history of.

6.44.6.8.5. Visual field defects, any type, including hemianopsia. **Note**: Testing will be accomplished on all Flying Class I and IA examinations, and annually for all flying personnel.

6.44.6.8.6. Abnormal pupils or loss of normal pupillary reflexes, with the exception of physiological anisocoria.

6.44.6.8.7. Retained intraocular foreign body.

6.44.6.8.8. Absence of an eye.

6.44.6.8.9. Anophthalmos or microphthalmus.

6.44.6.8.10. Any traumatic, organic, or congenital disorder of the eye or adnexa, not specified above, which threatens, or potentially threatens, to intermittently or permanently impair visual function.

6.44.6.8.11. Migraine or its variants, to include acephalgic migraine (see **6.44.23**).

6.44.6.8.12. History of any ocular surgery to include lasers of any type. See aircrew waiver guide.

6.44.7. **Vision and Refraction.**

Table 6.1. Vision & Refractive Error Standards.

Flying Class	Distant Vision		Near Vision		Any Meridian	Astig-matism	Aniso-metropia
	Uncorrected	Corrected	Uncorrected	Corrected			
I See **Notes**:	20/70	20/20	20/30	20/20	+2.00 to -1.50	1.50	2.00
IA See **Notes**:	20/200	20/20	20/40	20/20	+3.00 to -2.75	2.00	2.50
II (Pilot) ** See **Notes**:	20/400	20/20	-	20/20	+3.50 to -4.00	2.00	2.50
II/III (Non-pilot) ** See **Notes**:	20/400	20/20	-	20/20	+5.50 to -5.50	3.00	3.50

** Individuals found on routine examination to be 20/20 in one eye and 20/25 with current corrective lenses, but are correctable to 20/20 O.U. and who have normal stereopsis may continue flying until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means.

Notes:

1. All aircrew must be refracted to their best corrected manifest visual acuity. Near vision must be corrected to 20/20 at the nearest cockpit working distance. Use of spectacles to correct aircrew's distance visual acuity to better than 20/20, if possible, must be encouraged. However spectacle use is at the crew member's discretion if not required to meet flight standards. See Section 6F – USAF Corrective Lenses for prescription and non-prescription eyewear requirements.
2. Cycloplegic Policy: For initial qualification or for waiver consideration, a cycloplegic refraction must be done using 1% cyclopentolate (Cyclogel®), two drops, 5-15 minutes apart. Examination will be performed no sooner than one hour after the last drop and within two hours of the last drop of cyclopentolate. Required data: (1) minimum cycloplegic refractive power required for each eye to attain a visual acuity of 20/20. – aeromedical baseline; (2) cycloplegic refractive power required for each eye to attain best corrected visual acuity - clinical baseline. **Note**: aeromedical and clinical baseline data may not correlate. If 20/20 visual acuity cannot be attained under cycloplegic conditions, further clinical evaluation may be required.
3. Optional wear of contact lenses by aircrew members is outlined in Section 6F – USAF Corrective Lenses. Use of contact lenses for treatment of medical conditions or complex refractive errors is disqualifying.
4. Use of hard, rigid, or gas permeable (hard) contact lenses within 3 months before the examination or soft contact lenses 1 month before all initial flying examinations is prohibited. Document SF 88/DD Form 2808 appropriately to ensure this requirement has been met.
5. Complex refractive errors that can be corrected only by contact lenses are disqualifying.
6. All aircrew members are prohibited from using contact lenses for treatment of medical conditions unless they have been specifically prescribed and issued or approved by the ACS.

7. Optional wear of contact lenses for aircrew members is outlined in **Section 6F**.

8. Waivers may only be considered after the individual has a normal ophthalmological examination, to include a dilated fundus exam and meets the USAF standards with approved spectacles for aircrew duties (see **Section 6F**).

9. Near vision must be corrected to 20/20 at the nearest cockpit working distance.

10. Flying Class II/III aviators must be refracted to their best corrected manifest visual acuity. Use of spectacles to correct aircrew to better than 20/20 if possible, must be encouraged, but is at the discretion of the crewmember. Continued flying qualification are based on minimum cycloplegic refraction required to achieve 20/20.

11. For qualification purposes, cycloplegic refraction readings must be recorded for that required to read the 20/20 line in each eye. However, continue refraction to best visual acuity and report the best achievable corrected visual acuity as a clinical baseline. (Thus, acuity and refractive error numbers may not correlate). Cycloplegic refractions that cannot achieve the 20/20 line will need clinical evaluation or re-evaluation. Cycloplegic Policy: For qualification purposes, a cycloplegic refraction must be done using 1% cyclopentolate (Cyclogel®), two drops, 5-15 minutes apart. Examination will be performed no sooner than one hour after the last drop and within two hours of the last drop of cyclopentolate

12. Crewmembers who wear corrective spectacles or contact lenses must carry a spare set of clear prescription spectacles on their person while performing aircrew duties, see AFI 11-202, Vol 3, paragraph 6.3. Authorized eyewear are identified under the Aircrew Flight Frame (AFF) series as the AFF-OP (AFF), 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. See **Section 6F** for prescription and non-prescription eyewear requirements.

13. Determine the best possible visual acuity obtained in each eye with the OVT or VTA. The last row the examinee correctly identified all 10 letters will be recorded as the examinee's visual acuity.

6.44.8. **Heterophoria and Heterotropia.**

6.44.8.1. Flying Class III, not required to perform scanner duties (see the enlisted classification guide).

6.44.8.1.1. Esophoria greater than 15 prism diopters.

6.44.8.1.2. Exophoria greater than 8 prism diopters.

6.44.8.1.3. Hyperphoria greater than 2 prism diopters.

6.44.8.1.4. Heterotropia greater than 15 prism diopters, at near or distance.

6.44.8.2. Flying Class I, IA, II; and Flying Class III crewmembers required to perform scanner duties (see classification guide). If any of these are exceeded, then **6.44.11** applies. **Note:** For the purposes of this AFI, scanner duties are defined by the requirement to assist with safety clearance checks of their aircraft from outside obstacles, within 200 meters.

6.44.8.2.1. Esophoria greater than 10 prism diopters, at near or distance.

6.44.8.2.2. Exophoria greater than 6 prism diopters, at near or distance.

6.44.8.2.3. Hyperphoria greater than 1.5 prism diopters, at near or distance.

6.44.8.2.4. Heterotropia, including microtropias and monofixation syndrome, at near or distance.

6.44.8.2.5. Point of convergence (PC) greater than 100mm. **Note:** Accomplish and record PC measurements only at the time of initial Flying Class I, IA, II-Flight Surgeon, and III - Inflight Refueler applicant exams. The PC is no longer required on periodic examinations.

6.44.8.2.6. History of extraocular muscle surgery or strabismus therapies is disqualifying and requires complete evaluation of ocular motility by a competent eye care professional to look for residual heterophorias, heterotropias (including microtropias), and motor sensory problems. Paragraph **6.44.11** applies.

6.44.9. **Near Point of Accommodation.**

6.44.9.1. Flying Classes II and III. No standards.

6.44.9.2. Flying Classes I and IA. Near point of accommodation less than the value specified by age listed in **Table 6.2**

Table 6.2. Accommodative Power

Age	Diopters	Age	Diopters
17	8.8	32	5.1
18	8.6	33	4.9
19	8.4	34	4.6
20	8.1	35	4.3
21	7.9	36	4.0
22	7.7	37	3.7
23	7.5	38	3.4
24	7.2	39	3.1
25	6.9	40	2.8
26	6.7	41	2.4
27	6.5	42	2.0
28	6.2	43	1.5
29	6.0	44	1.0
30	5.7	45	0.6
31	5.4		

Example: An individual age 21 must have a measurement of 7.9 diopters or greater to pass. If the score is less than 7.9 (e.g. 7.2) they have a failing score.

6.44.10. **Color Vision.**

6.44.10.1. Cone Contrast Test (CCT) equipment will be sent to AF MTFs and ANG and AFRC units not co-located with an MTF no later than January 2011. Beginning 1 January 2011, or upon receipt of CCT equipment, all flying/special operational duty personnel or other career fields requiring color vision testing will be tested using both the CCT and PIP I/PIP II.

6.44.10.1.1. Passing score on the CCT is defined as 75 or greater on each of the three colors, red, green and blue. For additional implementation instructions and disposition of Airmen with failing scores, refer to the AFMS KX at: **https://kx.afms.mil/kxweb/dotmil/kjPage.do?functionalArea=AerospaceMedicine&cid=CTB_122236**.

6.44.10.1.1.1. PIP I (minimum passing score 12/14, tested monocularly).

Note: All USAFA and ROTC cadets receiving initial flight physicals during the 2009-2010 academic year will be held to the 10/14 PIP I standards. For the purposes of this AFI, the academic year will end 1 Jul 2010. All other aircrew who were previously qualified for flying duties based on the previous 10/14 PIP I and fail the new 12/14 PIP I standard will be considered for waiver in their current weapon system after appropriate evaluation. A formal ophthalmologic evaluation must be accomplished to determine the type and degree of color vision defect.

6.44.10.1.1.2. PIP II (minimum passing score 9/10 tested monocularly).

6.44.10.1.1.3. F2 Plate (able to correctly identify number, location and orientation of squares, tested monocularly, performed only during the Medical Flight Screening exam).

6.44.10.1.1.4. Confirmatory testing by the ACS on any history of color screening test failure, to include Anomaloscope and Cone Contrast Test, may be required.

6.44.10.2. Flying Class I. Color vision deficit or anomaly of any degree or type. See aircrew waiver guide.

6.44.10.2.1. All Flying Class I applicants must pass color vision testing during the initial FC I exam (PIP 1 and PIP II). If passed, subsequent MFS color vision screening testing includes the following approved tests by AF/SG.

6.44.10.2.1.1. PIP I (minimum passing score 12/14, tested monocularly).

6.44.10.2.1.2. PIP II (minimum passing score 9/10 tested monocularly).

6.44.10.2.1.3. F2 Plate (able to correctly identify number, location and orientation of squares, tested monocularly, performed only during the Medical Flight Screening exam).

6.44.10.2.1.4. Confirmatory testing by the ACS on any history of color screening test failure, to include Anomaloscope and Cone Contrast Test, may be required.

6.44.10.2.2. PIP II (minimum passing score 9/10, tested monocularly).

6.44.10.3. Flying Class IA/II/III: Must possess normal color vision as demonstrated by passing the approved PIP I and PIP II. Testing must be accomplished at each PHA. Follow up testing for previously waived color defectives will include at least the PIP I and PIP II and other testing as determined by AFMSA/SG3PF. See aircrew waiver guide.

6.44.10.3.1. PIP I (minimum passing score 12/14, tested monocularly).

6.44.10.3.2. PIP II (minimum passing score 9/10, tested monocularly).

6.44.10.4. Color vision screening done at base level must be performed monocularly under an approved and standardized illuminant (i.e., MacBeth easel lamp with a 100 watt

light bulb or a True Daylight AE lamp from Richmond Products). Three or more incorrect responses in either eye (including failure to make responses in the allowed time interval (no more than 5 seconds)) using either the Dvorine or Ishihara (14 test plate version) PIP I, is considered a failure. The same testing conditions and time intervals apply for the PIP II. The minimum passing score on the PIP II is no more than one incorrect response. No other PIP versions, such as the Richmond PIP, or Beck Engraving versions, or other PIP tests for color vision are authorized. Test scores must be recorded as number of correct/total number presented. The Farnsworth lantern test (FALANT) is not authorized.

6.44.10.5. Color defective aircrew with a valid waiver may wear issued neutral 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 (HCV).

6.44.10.6. AFMSA retains certification/waiver authority for all color vision deficiencies.

6.44.11. **Depth Perception/Stereopsis.**

6.44.11.1. Flying Class I, IA, II. Failure of either the Vision Test Apparatus (VTA-DP), or its newer replacement, the OVT is considered disqualifying if the failure occurs with best corrected visual acuity regardless of level of uncorrected visual acuity. See aircrew waiver guide.

6.44.11.1.1. Failure of the VTA or OVT stereopsis testing requires completion of a local preliminary ocular motility and macular examination by an ophthalmologist or optometrist, and review by both AETC and the ACS. The test must include **all** of the following**:**

6.44.11.1.1.1. Ductions, versions, cover test and alternate cover test in primary and 6 cardinal positions of gaze.

6.44.11.1.1.2. AO Vectograph Stereopsis Test at 6 meters (4 line version).

6.44.11.1.1.3. AO Suppression Test at 6 meters.

6.44.11.1.1.4. Randot or Titmus Stereopsis Test.

6.44.11.1.1.5. Red Lens Test.

6.44.11.1.1.6. Diopter Base out Prism Test at 6 meters. **Note:** These tests are designed to identify and characterize motility/alignment disorders, especially microtropias and monofixation syndrome and are required for new depth perception test failure, new diagnosis of ocular motility disorders, depth perception waiver renewals, if the previous level of waivered depth perception declines. The results of these tests done locally are considered to be preliminary, but will be used by waiver authorities to determine whether a candidate must be permanently disqualified without any waiver consideration, to identify if there are easily correctable causes (i.e., spectacles), and to determine whether further evaluation is required. These cases will be reviewed by HQ AETC/SGPS and HQ ARC/SGP IAW waiver guide policy.

6.44.11.2. For FC III, the requirement for normal depth perception is AFSC specific as stated in the classification guide per the career field manager. Failure of either the Vision Test Apparatus (VTA-DP), or its newer replacement, the OVT is considered disqualifying if the failure occurs with best corrected visual acuity regardless of level of uncorrected visual acuity.

6.44.11.2.2. All will be tested. All IFCIII physicals are required to have depth perception results recorded even if a specific AFSC does not require the standard to qualify for a particular career field. Results must be recorded and information put into PEPP and AIMWTS (e.g. VTA-DP fails D, AFSC does not require depth perception).

6.44.11.2.3. For those AFSCs that are identified in the classification guide as requiring depth perception, failure of the VTA or OVT stereopsis testing requires completion of a local preliminary ocular motility and macular examination by an ophthalmologist or optometrist, and review by both AETC and the ACS. The testing must be accomplished as listed in **6.44.11.1.1** above.

6.44.12. **Field of Vision.**

6.44.12.1. Flying Classes I, IA, II and III.

6.44.12.1.1. Contraction of the normal visual field in either eye to within 30 degrees of fixation in any meridian.

6.44.12.1.2. Central scotoma, whether active or inactive, including transitory migraine related or any other central scotoma which is due to active pathological process.

6.44.12.1.3. Any peripheral scotoma, other than physiologic.

6.44.13. **Night Vision, Flying Classes I, IA, II, and III.** Unsatisfactory night vision is determined by history for initial flying. In trained aviators, this history is confirmed, when clinically required, by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists. Dark field and empty field myopia due to accommodation are normal physiologic responses.

6.44.14. **Red Lens Test.**

6.44.14.1. Flying Classes II and III (except Inflight Refuelers, and scanners): No standards.

6.44.14.2. Flying Classes I, IA, and III-Inflight Refuelers, and Scanners (as defined in the note at **6.44.8.2** and as stated in the classification guide per the career field manager. Any diplopia or suppression during the Red Lens Test which develops within 20 inches of the center of the screen (30 degrees) is considered a failure. If failed, a complete preliminary local evaluation of ocular motility/alignment by a qualified ophthalmologist or optometrist as described in **6.44.11.1.1** is then required. The results of these tests done locally are considered to be preliminary, but will be used by waiver authorities and the ACS to determine whether a candidate must be permanently disqualified without any waiver consideration, to identify if there are potentially correctable causes, and to determine whether further evaluation is required. The Red Lens Test will be repeated for Flying Class I at MFS.

6.44.15. **Intraocular Pressure, Initial Flying Classes I, IA, II, and III.**

6.44.15.1. Glaucoma. As evidenced by intraocular pressures of 30 mmHg or greater by applanation tonometry, or the secondary changes in the optic disc or visual field associated with glaucoma. Trained aircrew with glaucoma require consultation (review or evaluation) with the ACS prior to waiver consideration. Note: Pigmentary dispersion syndrome (PDS) is not medically disqualifying for flying (includes Initial Flying Classes) unless associated with elevated intraocular pressures above 22 mmHg or greater by applanation tonometry.

6.44.15.2. Ocular hypertension (Preglaucoma). Two or more current applanation tonometry measurements of 22 mmHg or greater, but less than 30 mmHg, or 4 mmHg or more difference between the two eyes. **Note:** Abnormal pressures obtained by a noncontact (air puff) tonometer or Schiotz must be verified by applanation tonometry.

6.44.16. **Lungs and Chest Wall.**

6.44.16.1. Flying Classes II and III.

6.44.16.1.1. Pulmonary tuberculosis, including tuberculous pleuritis or pleurisy of unknown etiology with positive tuberculin test.

6.44.16.1.2. History of spontaneous pneumothorax. A single episode of spontaneous pneumothorax does not require waiver if PA inspiratory and expiratory chest radiograph and thin-cut CT-scan show full expansion of the lung and no demonstrable pathology which would predispose to recurrence.

6.44.16.1.3. Pulmonary blebs or bullae, unless corrected by surgical treatment, recovery is complete, and pulmonary function tests are normal.

6.44.16.1.4. Bronchiectasis.

6.44.16.1.5. Sarcoidosis.

6.44.16.1.6. Pleural effusion.

6.44.16.1.7. Empyema, or unhealed sinuses of the chest wall following surgery for empyema.

6.44.16.1.8. Chronic bronchitis, if pulmonary function is impaired to such a degree as to interfere with duty performance or to restrict activities.

6.44.16.1.9. Asthma of any degree, or a history of asthma, reactive airway disease, intrinsic or extrinsic bronchial asthma, exercise-induced bronchospasm, or IgE (Immunoglobulin E) mediated asthma.

6.44.16.1.10. Bullous or generalized pulmonary emphysema.

6.44.16.1.11. Cystic or cavitary disease of the lung.

6.44.16.1.12. Silicosis or extensive pulmonary fibrosis with functional impairment or abnormal pulmonary function tests.

6.44.16.1.13. History of lung abscess.

6.44.16.1.14. Chronic mycotic infection of the lung. Residuals of infection, including cavitation, except for scattered nodular parenchymal and hilar calcifications.

6.44.16.1.15. Foreign body in the trachea or bronchus.

6.44.16.1.16. Pleural fibrosis of sufficient extent to interfere with pulmonary function and exercise tolerance.

6.44.16.1.17. History of lobectomy, or multiple segmental resections, if there is significant reduction of vital capacity (<80%), or if there is residual pulmonary pathology.

6.44.16.1.18. Congenital malformation or acquired deformities, which reduce the chest capacity, or diminish respiratory or cardiac functions, to a degree which interferes with vigorous physical exertion.

6.44.16.1.19. Chronic cystic mastitis.

6.44.16.1.20. History of pulmonary embolus.

6.44.16.1.21. Silicone implants, injections, or saline inflated implants in breasts.

6.44.16.1.22. History of sleep apnea or other clinical sleep disorders.

6.44.16.2. Flying Classes I and IA. In addition to the above:

6.44.16.2.1. History of spontaneous pneumothorax. A single episode may be considered for waiver after 3 years if pulmonary evaluation shows complete recovery with full expansion of the lung, and no demonstrable pathology that would predispose to recurrence.

6.44.16.2.2. Chronic adhesive pleuritis which produces any findings except minimal blunting of the costophrenic angles.

6.44.16.2.3. History of sarcoidosis.

6.44.17. **Cardiovascular System.**

6.44.17.1. Flying Classes I, IA, II and III.

6.44.17.1.1. Elevated blood pressure measured in the sitting position. Any value that exceeds 140/90 is disqualifying as follows:

6.44.17.1.1.1. Average systolic pressure greater than 140 mmHg, or average diastolic pressure of greater than 90 mmHg obtained from the 3-day blood pressure check. **Note**: Asymptomatic personnel with average systolic blood pressure ranging between 141 mmHg and 160 mmHg, or average diastolic blood pressure ranging between 91 mmHg and 100 mmHg, may remain on flying status for up to 6 months (from the date the elevated blood pressure was first identified) while undergoing non-pharmacological intervention to achieve acceptable values. (For hypertension treated with medication, refer to aircrew waiver guide for details on waiver work-up and required information.)

6.44.17.1.1.2. History of elevated blood pressure requiring chronic medication for control.

6.44.17.1.1.3. Any elevation in blood pressure due to secondary metabolic or pathologic causes until the underlying cause has been corrected, provided the primary condition is not disqualifying.

6.44.17.1.2. History of cardiac surgery or catheter-based therapeutic intervention. See aircrew waiver guide.

6.44.17.1.3. History of cardiac failure or cardiomyopathy, regardless of cause.

6.44.17.1.4. History of significant traumatic heart disease**.**

6.44.17.1.5. Right or left ventricular hypertrophy or cardiac chamber dilation, verified by echocardiogram, unless evaluation and ACS review demonstrates it to be normal physiological response to athletic conditioning or other normal variant. See Disposition of ECG Findings guide.

6.44.17.1.6. Orthostatic or symptomatic hypotension, or recurrent vasodepressor syncope.

6.44.17.1.7. Pericarditis, myocarditis, or endocarditis, or history of these conditions. See aircrew waiver guide.

6.44.17.1.8. Congenital abnormalities of the heart and/or vessels, including those corrected by surgery or catheter-based therapeutic intervention.

6.44.17.1.9. Any degree of coronary artery disease. See aircrew waiver guide.

6.44.17.1.10. History of symptomatic or asymptomatic major dysrhythmia. Major dysrhythmias include supraventricular tachycardia, atrial tachycardia, atrial flutter, atrial fibrillation, ventricular tachycardia, ventricular flutter, ventricular fibrillation, asystole and syndrome of inappropriate sinus tachycardia. See aircrew waiver guide and Disposition of ECG Findings guide.

6.44.17.1.11. Verified history of major electrocardiographic conduction defects, such as Mobitz II second-degree A-V block, third degree A-V block, left bundle branch block (LBBB), Wolff-Parkinson-White (WPW) pattern/syndrome, or Lown-Ganong-Levine (LGL) syndrome. See aircrew waiver guide and Disposition of ECG Findings guide.

6.44.17.1.12. History of valvular heart disease to include mitral valve prolapse; bicuspid aortic valve; pulmonic, mitral, and tricuspid valvular regurgitation greater than mild, aortic regurgitation greater than trace, and any degree of valvular stenosis. See aircrew waiver guide.

6.44.17.1.13. Any other resting 12-lead ECG findings considered to be borderline or abnormal by ECG Library review, or known to be serial changes from previous records, unless a cardiac evaluation as directed and reviewed by the ACS/ECG Library reveals no underlying disqualifying disease. See “Disposition for ECG Findings” on the aircrew waiver guide for guidance whether the aviator/aircrew must be DNIF pending evaluation results and final recommendation from the ACS/ECG Library.

6.44.17.1.14. Abnormal noninvasive cardiac studies by ACS/EKG Library review. **Note:** For rated officers, reports and copies of tracings/images of any cardiac study,

(i.e., ECG, Holter monitor, echocardiogram, treadmill, stress myocardial perfusion imaging, CT scan for coronary calcium) accomplished for any clinical or aeromedical indication **MUST** be forwarded to the ACS/ECG Library for review.

6.44.17.1.15. Diseases and disorders of the aorta, including surgical or percutaneous therapeutic intervention, including but not limited to aneurysm, dissection, arteriosclerosis, collagen vascular disease, inflammatory conditions, and infectious diseases.

6.44.17.1.16. Diseases and disorders of the arteries, including surgical or percutaneous therapeutic intervention, including but not limited to aneurysm, dissection, arteriosclerosis, collagen vascular disease, inflammatory conditions, infectious diseases, Raynaud's disease, thromboangitis obliterans, erythromelalgia, and diabetic vascular disease.

6.44.17.1.17. Diseases and disorders of the veins, including surgical or percutaneous therapeutic intervention, including but not limited to aneurysm, thrombophlebitis, varicose veins with more than mild complications, inflammatory conditions, infectious conditions.

6.44.18. **Blood, Blood-Forming Tissue, and Immune System Diseases.** Flying Classes I, IA, II and III:

6.44.18.1. Anemia of any etiology. Hematocrit values less than 40 for men or 35 for women must be evaluated; decreasing hematocrit values, even if in the normal range, may also be an indication for workup. Waiver for trained aircrew is permissible for stable anemia not due to an otherwise disqualifying condition, as long as the hematocrit does not fall below 32 percent.

6.44.18.2. Loss of 200 cc or more of blood is disqualifying for at least 72 hours. This includes blood donation, plasma donation and platelet phoresis. See aircrew waiver guide.

6.44.18.3. Polycythemia; a hematocrit above 50 in men, or above 47 in women, must be evaluated. Waiver is not favorably considered if the hematocrit is above 55 percent.

6.44.18.4. Hemoglobinopathies and thalassemias.

6.44.18.4.1. Homozygous hemoglobin abnormalities.

6.44.18.4.2. Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

6.44.18.4.3. Sickle cell trait if the individual has a history of symptoms associated with a sickling disorder or symptomology attributable to intravascular sickling during decompression in an altitude chamber. A one-time certification, by the proper certification authority in **Attachment 2**, is required for all flying personnel and flying training applicants with sickle cell trait after evaluation as outlined in the aircrew waiver guide.

6.44.18.5. Hemorrhagic states and thromboembolic disease:

6.44.18.6. Immunodeficiency syndromes, primary or acquired. Confirmed presence of HIV or antibody. AFMSA/SG3P retains waiver authority for all flying classes. See aircrew waiver guide.

6.44.18.7. Generalized lymphadenopathy or splenomegaly, until the cause is corrected.

6.44.19. **Abdomen and Gastrointestinal System.**

6.44.19.1. Flying Classes I, IA, II and III.

6.44.19.1.1. Gastrointestinal hemorrhage, or history of, regardless of cause. Waiver may be considered for any condition that is clearly attributable to a specific, nonpersistent cause. See aircrew waiver guide.

6.44.19.1.2. Peptic ulcer disease, active or refractory.

6.44.19.1.3. Peptic ulcer complicated by hemorrhage, obstruction or perforation.

6.44.19.1.4. Hernia, other than small asymptomatic umbilical or hiatal.

6.44.19.1.5. History of viral hepatitis, with carrier status, persistent transaminase elevation, or evidence of chronic active or persistent hepatitis.

6.44.19.1.6. Wounds, injuries, scars, or weakness of the muscles of the abdominal wall which are sufficient to interfere with function.

6.44.19.1.7. Sinus or fistula of the abdominal wall.

6.44.19.1.8. Chronic or recurrent esophagitis including reflux esophagitis.

6.44.19.1.9. Chronic gastritis.

6.44.19.1.10. Congenital abnormalities of the bowel if symptomatic or requiring surgical treatment. History of intestinal obstruction if due to any chronic or recurrent disease. Surgery to relieve childhood pyloric stenosis or intussusception is not disqualifying, if there is no residual dysfunction.

6.44.19.1.11. Crohn's disease (regional enteritis).

6.44.19.1.12. Malabsorption syndromes (see **6.44.28**).

6.44.19.1.13. Irritable bowel syndrome.

6.44.19.1.14. Ulcerative colitis, or proctitis or verified history of same.

6.44.19.1.15. Chronic diarrhea, regardless of cause.

6.44.19.1.16. Megacolon.

6.44.19.1.17. Diverticulitis, symptomatic diverticulosis, or symptomatic Meckel's diverticulum.

6.44.19.1.18. Marked enlargement of the liver from any cause. Hepatic cysts. Congenital hyperbilirubinemias, i.e. Gilbert's disease, do not require waiver if asymptomatic. See aircrew waiver guide.

6.44.19.1.19. Chronic cholecystitis.

6.44.19.1.20. Cholelithiasis that is symptomatic or requires ongoing therapy.

6.44.19.1.21. Sphincter of oddi dysfunction, or bile duct abnormalities or strictures.

6.44.19.1.22. Pancreatitis, or history of same.

6.44.19.1.23. Congenital anomalies, disease of the spleen. Chronic enlargement of the spleen.

6.44.19.1.24. Splenectomy, for any reason except the following:

6.44.19.1.24.1. Trauma to an otherwise healthy spleen.

6.44.19.1.24.2. Hereditary spherocytosis.

6.44.19.1.25. History of gastroenterostomy, gastrointestinal bypass, stomach stapling, or surgery for relief of intestinal adhesions.

6.44.19.1.26. Symptomatic esophageal motility disorders (including Gastroesophageal Reflux Disease) not controlled by medications listed in "Official Air Force Approved Aircrew Medications", updated periodically by AFMSA (approved by AF/SG3P). **Note:** See Aircrew Waiver Guide.

6.44.19.1.27. History of partial resection of the large or small intestines for chronic or recurrent disease.

6.44.20. **Perianal, Rectum, and Prostate: Flying Classes I, IA, II, and III.**

6.44.20.1. Proctitis, chronic, or symptomatic.

6.44.20.2. Stricture or prolapse of the rectum.

6.44.20.3. Hemorrhoids which cause marked symptoms, or internal hemorrhoids which hemorrhage or protrude intermittently or constantly, until surgically corrected.

6.44.20.4. Fecal incontinence.

6.44.20.5. Anal fistula.

6.44.20.6. Ischiorectal abscess.

6.44.20.7. Chronic anal fissure.

6.44.20.8. Symptomatic rectocele.

6.44.20.9. Pilonidal cyst, if there is a history of inflammation or discharging sinus in the 2 years preceding examination. Surgery for pilonidal cyst or sinus is disqualifying until the wound is healed, there are no referable symptoms, and no further treatment or medication is required.

6.44.20.10. Chronic prostatitis and symptomatic prostatic hypertrophy.

6.44.21. **Genitourinary System: Flying Class I, IA, II and III.**

6.44.21.1. History of recurrent or bilateral renal calculus. Uncomplicated single episode of renal calculus does not require waiver, but must be evaluated. See aircrew waiver guide.

6.44.21.2. Retained renal calculus. A subset of retained calculus may be considered for waiver. See aircrew waiver guide.

6.44.21.3. Proteinuria under normal activity (at least 48 hours post strenuous exercise) greater than 200 mg in 24 hours. Waiver may be considered for fixed and reproducible orthostatic proteinuria when the urinary protein to urinary creatinine ratio on a randomly collected urine (not first morning void) is less than or equal to 0.2. It is not necessary to collect a 24 hour urine specimen.

6.44.21.4. Persistent or recurrent hematuria.

6.44.21.5. Cylindruria, hemoglobinuria, or other findings indicative of significant renal disease.

6.44.21.6. Chronic glomerulonephritis or nephrotic syndrome.

6.44.21.7. Stricture of the urethra.

6.44.21.8. Urinary fistula.

6.44.21.9. Urinary incontinence.

6.44.21.10. Absence of one kidney.

6.44.21.11. Functional impairment of either or both kidneys.

6.44.21.12. Horseshoe kidney.

6.44.21.13. Chronic pyelitis or pyelonephritis.

6.44.21.14. Renal ptosis (floating kidney) causing impaired renal drainage, hypertension, or pain.

6.44.21.15. Hydronephrosis, or pyonephrosis.

6.44.21.16. Polycystic kidney disease.

6.44.21.17. Chronic cystitis.

6.44.21.18. Hermaphroditism.

6.44.21.19. Epispadias or hypospadias with unsatisfactory surgical correction.

6.44.21.20. Hydrocele, unless small and asymptomatic.

6.44.21.21. Large or painful left varicocele. Any right varicocele, unless significant underlying pathology has been excluded.

6.44.21.22. Undescended testicle. Absence of both testicles.

6.44.21.23. Chronic orchitis, or epididymitis.

6.44.21.24. Urinary diversion.

6.44.21.25. Major abnormalities and defects of the genitalia such as a change of sex, a history thereof, or complications (such as adhesions or disfiguring scars) residual to surgical correction of these conditions.

6.44.22. **Pelvic.**

6.44.22.1. Flying Classes I, IA, II and III.

6.44.22.1.1. Pregnancy or other symptomatic enlargement of the uterus due to any cause. Flight surgeons shall educate female pilots during annual PHAs that pregnancy is disqualifying. Pregnancy waivers for trained flying personnel may be requested under the following guidelines: the request is voluntary and must be initiated by the crewmember with concurrence by the squadron commander, flight surgeon, and obstetrical provider. Physiological training is waived during pregnancy; flying is restricted to pressurized multi-crew, multi-engine, non-ejection seat aircraft; and crewmembers are released from all mobility commitments. The waiver is valid for the 13th through 24th week of gestation. See aircrew waiver guide. **Note:** Refer to AFRCI 41-104, *Pregnancy of Air Force Reserve Personnel* for further guidance on unit assigned reservists.

6.44.22.1.2. Chronic symptomatic vaginitis.

6.44.22.1.3. Chronic salpingitis or oophoritis.

6.44.22.1.4. Symptomatic uterine fibroids.

6.44.22.1.5. Symptomatic ovarian cysts.

6.44.22.1.6. All symptomatic congenital abnormalities of the reproductive system.

6.44.22.1.7. Dysmenorrhea, if incapacitating to a degree which necessitates recurrent absences of more than a few hours from routine duty.

6.44.22.1.8. Gross irregularity of the menstrual cycle. Menorrhagia, metrorrhagia, polymenorrhea, or amenorrhea is symptomatic, and interferes with performance of duties.

6.44.22.1.9. Menopausal syndrome, either physiologic or surgical, if manifested by more than mild constitutional or psychological symptoms.

6.44.22.1.10. Endometriosis.

6.44.22.1.10.1. Symptomatic or controlled medically.

6.44.22.1.10.2. History of, is disqualifying for FC I/IA.

6.44.22.1.11. Malposition of the uterus, if symptomatic.

6.44.22.1.12. Vulvitis, chronic.

6.44.23. **Neurological Disorders.**

6.44.23.1. Flying Classes II and III.

6.44.23.1.1. Infections of the Central Nervous System (CNS).

6.44.23.1.2. Seizure of any type (grand mal, petit mal, focal, etc.).

6.44.23.1.3. Disturbances of consciousness (not due to head injury).

6.44.23.1.3.1. An isolated episode of neurocardiogenic syncope associated with venipunture, or prolonged standing in the sun (or similar benign precipitating event) which is less than 1 minute in duration, without loss of continence, and followed by rapid and complete recovery without sequelae, does not require waiver if thorough neurological and cardiovascular evaluation by a flight surgeon

reveals no abnormalities. See aircrew waiver guide.

6.44.23.1.3.2. Physiological loss of consciousness (LOC) caused by reduced oxygen tension, general anesthesia, or other medically induced LOC (excluding vasovagal syncope) does not require waiver provided there is full recovery without sequelae.

6.44.23.1.3.3. G induced loss of consciousness (G-LOC) during a centrifuge run does not require waiver for continued flying duty, unless there are neurologic sequelae, or evidence that the G-LOC occurrence is associated with coexistant disease or anatomic abnormality. Inflight G-LOC caused by an improperly performed anti-G straining maneuver, or a disconnect of the anti-G protective gear is not disqualifying, and is managed as a physiological incident. The local flight surgeon completes appropriate post-incident medical evaluation and reports the incident according to applicable directives. See aircrew waiver guide.

6.44.23.1.3.4. All other loss or disturbance of consciousness. For rated personnel, waivers are considered by AFMSA/SG3P, only after evaluation at ACS. For non-rated personnel, waiver is at MAJCOM discretion. See aircrew waiver guide. **Note:** Flying training applicants and students with a history of syncope and/or loss of consciousness, evaluated according to aircrew waiver guide, and certified acceptable for Flying Class I or IA by HQ AETC/SG, do not require an additional waiver for flying Class II for the same history of syncope.

6.44.23.1.4. History of any of the following types of headaches.

6.44.23.1.4.1. Recurrent headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

6.44.23.1.4.2. A single incapacitating headache of any type (e.g. loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

6.44.23.1.4.3. Headache of any type which are of sufficient severity to likely interfere with flying duties.

6.44.23.1.4.4. Acephalgic migraines.

6.44.23.1.5. Electroencephalographic abnormalities.

6.44.23.1.5.1. Truly epileptiform abnormalities to include generalized, lateralized, or focal spikes, sharp waves, spike-wave complexes, and sharp and slow wave complexes during alertness, drowsiness, or sleep are disqualifying. Benign transients such as Small Sharp Spikes (SSS) or Benign Epileptiform Transients of Sleep (BETS), wicket spikes, 6 Hertz (Hz) (phantom) spike and wave, rhythmic temporal theta of drowsiness (psychomotor variant), and 14 and 6Hz positive spikes are not disqualifying.

6.44.23.1.5.2. Generalized, lateralized, or focal continuous polymorphic delta activity or intermittent rhythmic delta activity (FIRDA or OIRDA) during the alert state is disqualifying, unless the etiology of the abnormality has been identified and determined not to be a disqualifying disorder.

6.44.23.1.6. History of head injury.

6.44.23.1.6.1. Head injuries associated with any of the following are not waiverable:

6.44.23.1.6.1.1. Post-traumatic seizures. **Exception**: seizures at the time of injury.

6.44.23.1.6.1.2. Persistent neurological deficits indicative of significant parenchymal CNS injury, such as hemiparesis or hemianopsia.

6.44.23.1.6.1.3. Evidence of impairment of higher intellectual functions or alterations of personality as a result of injury.

6.44.23.1.6.1.4. Cerebrospinal fluid shunts.

6.44.23.1.6.2. Severe head injury. Head trauma associated with any of the complications listed below may be considered for Flying Class II and III waiver in 5 years see aircrew waiver guide.

6.44.23.1.6.2.1. Unconsciousness or amnesia, or the combination of the two equal to, or exceeding, 24 hours duration. **Note:** In cases which are defined as severe only due to the duration of loss of consciousness or amnesia, and are otherwise minimal, mild, or moderate, a waiver at 2 years may be considered if the evaluation requirements in aircrew waiver guide are met.

6.44.23.1.6.2.2. Radiographic evidence of retained metallic or bony fragments.

6.44.23.1.6.2.3. Leptomeningeal cysts, aerocele, brain abscess, or arteriovenous fistula.

6.44.23.1.6.2.4. Depressed skull fracture (the inner table indented by more than the thickness of the skull) with, or without, dural penetration.

6.44.23.1.6.2.5. Traumatic or surgical laceration or contusion of the dura mater or the brain, or a history of penetrating brain injury.

6.44.23.1.6.2.6. Focal neurological signs.

6.44.23.1.6.2.7. Epidural, subdural, subarachnoid, or intracerebral hematoma. **Note:** A small epidural collection of blood found only on CT-scan or MRI, and without evidence of parenchymal injury either on the imaging study or on neurological examination, followed to resolution without surgery, may be considered for Flying Class II or III waiver at two years as in the moderate head injury group.

6.44.23.1.6.2.8. CNS infection, such as abscess or meningitis, within 6 months of head injury.

6.44.23.1.6.2.9. Cerebrospinal fluid rhinorrhea, or otorrhea, persisting more than 7 calendar days.

6.44.23.1.6.3. Moderate head injury. Head trauma associated with the following criteria may be considered for Flying Class II or III waiver in 2 years see aircrew waiver guide.

6.44.23.1.6.3.1. Unconsciousness for a period of 30 minutes or greater, but less than 24 hours.

6.44.23.1.6.3.2. Amnesia for a period of 1 hour or greater, but less than 24 hours. (Waiver contingent on a completely normal neurological and neuropsychological evaluation to include computerized tomography (CT) scan.) See aircrew waiver guide. **Exception:** Waiver may be considered after 6 months of observation if a normal CT-scan was obtained within 2 calendar days of injury. **Note:** In cases which are defined as moderate only due to the duration of loss of consciousness or amnesia and are otherwise minimal, mild, a waiver at 6 months may be considered if the evaluation requirements in the aircrew waiver guide are met.

6.44.23.1.6.4. Mild head injury. Head trauma, which does not meet criteria for more severe injury, may be considered for waiver after l month see aircrew waiver guide.

6.44.23.1.6.5. Head trauma with no loss of consciousness, amnesia, or abnormal findings on examination, does not require waiver.

6.44.23.1.6.6. Persistent post-traumatic sequelae, as manifested by headache, vomiting, disorientation, spatial disequilibrium, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome are disqualifying, but may be considered for waiver when full recovery has been confirmed by complete neurological and neuropsychological evaluation.

6.44.23.1.7. Craniotomy and skull defects.

6.44.23.1.8. Neurosyphilis in any form (meningovascular, tabes dorsalis, or general paresis).

6.44.23.1.9. Narcolepsy, cataplexy, and similar states.

6.44.23.1.10. Injury of one or more peripheral nerves, unless it is not expected to interfere with normal function in any practical manner.

6.44.23.1.11. History of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriosclerosis, arteriovenous malformation, or aneurysm involving the CNS.

6.44.23.1.12. History of tumor involving the brain or its coverings.

6.44.23.1.13. Personal or family history (second degree relative or closer) of hereditary disturbances, such as multiple neurofibromatosis, Huntington's chorea, hepatolenticular degeneration, acute intermittent porphyria, spinocerebellar ataxia, peroneal muscular atrophy, muscular dystrophy, and familial periodic paralysis.

6.44.23.1.14. Probable evidence, or history, of degenerative or demyelinating process such as multiple sclerosis, dementia, basal ganglia disease, or Friedreich's ataxia.

6.44.23.1.15. History or evidence of such defects as basilar invagination, hydrocephalus, premature closure of the cranial sutures, meningocele, and cerebral or

cerebellar agenesis, if there is evidence of impairment of normal functions, or if the process is expected to be progressive.

6.44.23.1.16. Verified history of neuritis, neuralgia, neuropathy, or radiculopathy, whatever the etiology, unless:

6.44.23.1.16.1. The condition has completely subsided, and the cause is determined to be of no future concern.

6.44.23.1.16.2. There is no residual which could be deemed detrimental to normal function in any practical manner.

6.44.23.1.17. Polyneuritis, whatever the etiology, unless:

6.44.23.1.17.1. Limited to a single episode.

6.44.23.1.17.2. The acute state subsided at least 1 year before examination.

6.44.23.1.17.3. There is no residual, which could be expected to interfere with normal function in any practical manner.

6.44.23.1.18. History or evidence of chronic or recurrent diseases, such as myasthenia gravis, polymyositis, or myotonia disorder.

6.44.23.1.19. Evidence or history of involvement of the nervous system by a toxic, metabolic or disease process, if there is any indication such involvement is likely to interfere with prolonged normal function in any practical manner, or is progressive or recurrent, or if there is a significant neurological residual which would interfere with aviation duties.

6.44.23.1.20. Tremors, chorea, dystonia, or other movement disorders which could interfere with aviation or normal function.

6.44.23.2. Flying Classes I and IA.

6.44.23.2.1. In addition to the above, convulsive disorders, seizures associated with febrile illness before 5 years of age may be acceptable with waiver if recent neurological evaluation, MRI, and EEG including awake and sleep samples are normal. See aircrew waiver guide.

6.44.23.2.2. History of severe head injury is usually not waiverable, and may not be considered until at least 10 years post injury. See aircrew waiver guide.

6.44.24. **Psychiatric Disorders.** (Reference most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association).

6.44.24.1. Flying Classes II and III.

6.44.24.1.1. Eating Disorders.

6.44.24.1.2. Gender Identity Disorders.

6.44.24.1.3. Mental Disorders due to a General Medical Condition.

6.44.24.1.4. Delirium, Dementia, and Amnestic Disorders, and Other Cognitive Disorders.

6.44.24.1.5. Substance use disorders. These conditions may be waived by MAJCOM/SGPA for a period no greater than three years, in accordance with the requirements in **6.44.24.1.5** to **6.44.24.1.5.4** In order to be considered for waiver, two conditions must be met: individual must have successfully completed treatment (defined in **6.44.24.1.5.1** as determined and documented by the MTF Alcohol & Drug Abuse Prevention & Treatment (ADAPT) program treatment team; and the individual must comply with post-treatment aftercare program requirements (see **6.44.24.1.5.2**). Also, see Aircrew waiver guide.

6.44.24.1.5.1. Treatment Program Requirements. Individuals will have successfully completed treatment when the following conditions are met: 1) They meet the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for early full remission of substance dependence or no longer meet diagnostic criteria for substance abuse; 2) The treatment team determines, based on DSM criteria, individual's progress towards agreed-upon goals and/or issues as stated in the treatment plan; and 3) They remain abstinent without the need for medication.

6.44.24.1.5.2. Post-treatment Aftercare Program Requirements. The individual must remain abstinent without the need for medication, document participation in an organized substance use aftercare program (e.g., Alcoholics Anonymous-(AA), or other program approved by the MTF ADAPT Program Manager), and meet with the designated professionals for the following specific timeframes:

Table 6.3. Aftercare Program Meeting Timeframes

Professional/Meetings	First Year	Second/Third Year	Fourth Year
Flight Surgeon	Monthly	Quarterly	Annually
ADAPT	Monthly	Monthly	N/A
Psychiatrist, Psychologist, Social Worker	Annually	Annually	N/A
Organized substance use aftercare program	3x weekly	1x weekly	Recommended (not required)

Notes:

1. The flight surgeon has primary responsibility for collecting and submitting the required documentation for waiver submission. The ADAPT representative documents substance use aftercare program attendance. Temporary modification of aftercare program requirements because of operational demands must be documented by the flight surgeon.
2. Initial waiver may be requested after "treatment program completion" (as defined in **6.44.24.1.5.1.**) and successful completion of 90 days in the post-treatment aftercare program.

6.44.24.1.5.3. Unsatisfactory Progress in Aftercare Program. The following pertain to any individual who fails to remain abstinent or otherwise not comply with all aftercare program requirements: Ground the member and arrange for re-evaluation by flight surgeon and ADAPT provider to determine potential for re-treatment. If member is determined to have potential for re-treatment, follow the initial waiver and aftercare program processes. If member is determined not to have potential for re-treatment, an AMS must be submitted for permanent disqualification. A second waiver request for substance use disorder (**6.44.24.1.5**) may be considered in accordance with initial waiver requirements,

but requested no sooner than 12 months from the last date that non-compliance with the post-treatment aftercare program was documented. Second waiver requests are considered on a case-by-case basis only, and waiver authority for these individuals is AFMSA/SG3P.

6.44.24.1.5.4. As part of the waiver package, the individual states in writing that they understand the waiver is valid, only if total abstinence from substance is maintained, and that a verifiable break in abstinence, once the waiver period has begun, is considered medically disqualifying. This written statement, kept in the medical records, must be accomplished at the initial waiver request, and re-accomplished each time a waiver renewal is requested.

6.44.24.1.6. Schizophrenia and other Psychotic Disorders.

6.44.24.1.7. Mood Disorders.

6.44.24.1.7.1. Depressive disorders including major depression, dysthymia, cyclothymia, and depression, not otherwise specified.

6.44.24.1.7.2. Bipolar disorder.

6.44.24.1.8. Anxiety Disorders. If the flight surgeon determines that the problem is due to a non-phobic "fear of flying" or (in a trainee) a "manifestation of apprehension," then the disposition is considered administrative and not medical.

6.44.24.1.9. Somatoform Disorders.

6.44.24.1.10. Dissociative Disorders.

6.44.24.1.11. Sexual paraphilias are not medically disqualifying; however, individuals meeting diagnostic criteria are dealt with administratively.

6.44.24.1.12. Sexual dysfunctions and sexual disorders, not otherwise specified are not medically disqualifying unless in association with another Axis I disorder.

6.44.24.1.13. Sleep disorders, if of such magnitude to warrant somatic treatment greater than 30 days duration, or if associated with an Axis I disorder other than an adjustment disorder.

6.44.24.1.14. Factitious Disorders.

6.44.24.1.15. Impulse Control Disorders, not elsewhere classified.

6.44.24.1.16. Adjustment Disorders of more than 60 days duration.

6.44.24.1.17. Unsatisfactory ARMA. Maladaptive personality traits (not meeting diagnostic criteria for a personality disorder), or a pattern of maladaptive behavior that significantly interferes with safety of flight, crew coordination, or mission completion. In the absence of maladaptive personality adjustment, traits, or behavior patterns, motivational issues are managed administratively and the AR must be rated satisfactory.

6.44.24.1.18. Psychological Factors Affecting Medical Condition.

6.44.24.1.19. Personality disorder that is severe enough to repeatedly manifest itself by significant interference with safety of flight, crew coordination, or mission completion; but can not be used as a medical reason for separation from active duty.

6.44.24.1.20. History of attempted suicide or suicidal behavior.

6.44.24.1.21. Current or history of anxiety disorder including, but not limited to, generalized anxiety disorder, phobic disorders, obsessive-compulsive disorder, posttraumatic stress disorder, and acute stress disorder.

6.44.24.2. Flying Classes I and IA. In addition:

6.44.24.2.1. History of any of the diagnoses listed at **6.44.24.1**, excluding verifiable simple adjustment disorders not requiring hospitalization.

6.44.24.2.2. History of schizophrenia in both parents, or bipolar disorder in both parents.

6.44.24.2.3. Unsatisfactory adaptability rating for military aviation.

6.44.24.2.4. Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder or Perceptual/Learning Disorder(s), unless the individual can demonstrate passing academic performance and there has been no use of medication(s) in the past 12 months.

6.44.24.2.5. Evidence of any condition causing serious chronic impairment of educational goals, or chronic behavioral difficulties requiring hospitalization or prolonged treatment.

6.44.25. **Extremities, Flying Classes I, IA, II, and III.**

6.44.25.1. General Conditions.

6.44.25.1.1. Arthritis of any type of more than minimal degree, which interferes with the ability to follow a physically active lifestyle, or may reasonably be expected to preclude the satisfactory performance of flying duties.

6.44.25.1.2. Documented history or findings of rheumatoid arthritis.

6.44.25.1.3. Active osteomyelitis, or a verified history of osteomyelitis, unless inactive with no recurrence during the 2 years before examination, and without residual deformity sufficient to interfere with function.

6.44.25.1.4. Osteoporosis.

6.44.25.1.5. Osteochondromatosis or multiple cartilaginous exostoses.

6.44.25.1.6. Disease or injury, or congenital anomaly of any bone or joint, with residual deformity, instability, pain, rigidity, or limitation of motion, if function is impaired to such a degree it interferes with training, physically active lifestyle, or flying duties.

6.44.25.1.7. Unreduced dislocation; substantiated history of recurrent dislocations or subluxations of a major joint, if not satisfactorily corrected.

6.44.25.1.8. Instability of a major joint, if symptomatic and more than mild, or if subsequent to surgery there is evidence of instability, weakness, or significant atrophy.

6.44.25.1.9. Malunited fractures which interfere significantly with function.

6.44.25.1.10. Symptomatic nonunion of fractures.

6.44.25.1.11. Any retained orthopedic fixation device that interferes with function or easily subject to trauma.

6.44.25.1.12. Muscular paralysis, paresis, contracture, or atrophy, if progressive, or of sufficient degree to interfere with the performance of flying duties.

6.44.25.1.13. Demonstrable loose body in any joint (includes osteocartilaginous or metallic foreign objects).

6.44.25.1.14. Synovitis with persistent swelling or limitation of motion.

6.44.25.1.15. Osteonecrosis.

6.44.25.1.16. Chondromalacia, if symptomatic, or there is verified history of joint effusion, interference with function, or residuals from surgery.

6.44.25.1.17. Joint replacement.

6.44.25.1.18. Myotonia congenita.

6.44.25.1.19. Scars, extensive, deep or adherent to the skin and soft tissues or neuromas of an extremity which are painful, interfere with movement, preclude the wearing of equipment, or show a tendency to breakdown.

6.44.25.1.20. Symptomatic amputation stump (neuroma, bone spur, adherent scar or ulceration).

6.44.25.2. Upper Extremity.

6.44.25.2.1. Absence of any segment of the hand or digits.

6.44.25.2.2. Resection of a joint other than that of a finger.

6.44.25.2.3. Hyperdactylia.

6.44.25.2.4. Scars and deformities of the fingers, or hand, which impair circulation, are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of flying duties.

6.44.25.2.5. Healed disease or injury of the wrist, elbow or shoulder with residual weakness or symptoms of such a degree as to interfere with the satisfactory performance of flying duty. Grip strength of less than 75 percent of predicted normal when compared with the normal hand (non-dominant is 80 percent of dominant grip).

6.44.25.2.6. Limitation of motion.

6.44.25.3. Lower Extremity.

6.44.25.3.1. Amputation or absence of any portion of the foot, or lower extremity, in excess of 1 of the 2nd through 5th toes.

6.44.25.3.2. Clubfoot of any degree.

6.44.25.3.3. Rigid or spastic flatfoot, symptomatic flatfoot, tarsal coalition.

6.44.25.3.4. Weak foot with demonstrable eversion of the foot, valgus of the heel, or marked bulging of the inner border due to inward rotation of the talus regardless of the presence or absence of symptoms.

6.44.25.3.5. Elevation of the longitudinal arch (pes cavus), if of enough degree to cause subluxation of the metatarsal heads and clawing of the toes. Obliteration of the transverse arch associated with permanent flexion of the small toes.

6.44.25.3.6. Any condition, disease, or injury to feet or toes which results in disabling pain, distracting discomfort, inability to satisfactorily perform military aviation, or precludes wear of proper military footgear.

6.44.25.3.7. Verified history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease), or slipped femoral epiphysis of the hip with X-ray evidence of residual deformity or degenerative changes.

6.44.25.3.8. Verified history of hip dislocation within 2 years of examination, or degenerative changes on X-ray from old hip dislocation.

6.44.25.3.9. Difference in leg length of more than 2.5 centimeters (from anterior superior iliac spine to the distal tip of the medial malleolus).

6.44.25.3.10. Weak Knee. Dislocation of semilunar cartilages or loose foreign bodies within the knee joint; or residual instability of the knee ligaments; or significant atrophy or weakness of the thigh musculature in comparison with the normal side; or limited range of motion or other symptoms of internal derangement; or a condition which would interfere with the performance of flying duties.

6.44.25.3.11. Osteochondritis dessicans of the knee, or ankle, if there are X-ray changes.

6.44.25.3.12. Osteochondritis of the tibial tuberosity (Osgood-Schlatter disease), if symptomatic, or with obvious prominence of the part, and X-ray evidence of separated bone fragments.

6.44.25.3.13. Limitation of motion.

6.44.25.3.14. Toes-stiffness which interferes with walking, marching, running, or jumping.

6.44.26. **Spine and Other Musculoskeletal.**

6.44.26.1. Flying Classes I and IA, II and III.

6.44.26.1.1. History of disease or injury of the spine or sacroiliac joints, either with or without objective signs, which has prevented the examinee from successfully following a physically active lifestyle.

6.44.26.1.2. Arthritis of the spine, all types.

6.44.26.1.3. Granulomatous disease of the spine, active or healed.

6.44.26.1.4. Lumbar scoliosis of more than 20 degrees or thoracic scoliosis of more than 25 degrees as measured by the Cobb method.

6.44.26.1.5. Abnormal curvature of the spine of any degree in which there is a noticeable deformity when the examinee is dressed, in which pain or interference with function is present, or which is progressive.

6.44.26.1.6. Symptomatic spondylolisthesis or spondylolysis.

6.44.26.1.7. History of frank herniated nucleus pulposus, or history of surgery or chemonucleolysis for that condition.

6.44.26.1.8. Fractures or dislocations of the vertebrae. History of fractures of the transverse processes is not disqualifying if asymptomatic. See aircrew waiver guide for waiverable spinal fractures.

6.44.26.1.9. Spina bifida, when more than one vertebra is involved, if there is dimpling of the overlying skin, or a history of surgical repair for spina bifida.

6.44.26.1.10. Juvenile epiphysitis with any degree of residual change indicated by x-ray or kyphosis.

6.44.26.1.11. Weak or painful back requiring external support.

6.44.26.1.12. Recurrent disabling low back pain due to any cause.

6.44.26.1.13. Any surgical fusion.

6.44.27. **Skin.**

6.44.27.1. Flying Classes II and III.

6.44.27.1.1. Any chronic skin disorder, which is severe enough to cause recurrent grounding from flying duties, or is aggravated by, or interferes with, the wearing of military equipment.

6.44.27.1.2. Extensive, deep, or adherent scars, which interfere with muscular movements, with the wearing of military equipment (inclusive of, but not limited to, life support equipment, personal protective equipment or any other equipment necessary for performing military duties), or show a tendency to breakdown.

6.44.27.1.3. Atopic dermatitis with active or residual lesions controlled with chronic topical steroids.

6.44.27.1.4. Dermatitis herpetiformis.

6.44.27.1.5. Eczema, chronic and resistant to treatment.

6.44.27.1.6. Fungal infections of the skin, systemic or superficial, that interfere with duty performance or the wear of life support equipment.

6.44.27.1.7. Furunculosis, which is extensive, recurrent or chronic.

6.44.27.1.8. Hyperhidrosis, if chronic or severe.

6.44.27.1.9. Leukemia cutis; mycosis fungoides; Hodgkin’s disease.

6.44.27.1.10. Lichen planus.

6.44.27.1.11. Neurofibromatosis.

6.44.27.1.12. Photodermatosis, unless due to medication.

6.44.27.1.13. Psoriasis.

6.44.27.1.14. Scleroderma.

6.44.27.1.15. Xanthoma, if symptomatic, or accompanied by hypercholesterolemia or hyperlipoproteinemia.

6.44.27.1.16. Chronic urticaria.

6.44.27.2. Flying Classes I and IA. In addition to **6.44.27.1**, verified history after age 8 of atopic dermatitis, eczema, and/or psoriasis.

6.44.28. **Endocrine and Metabolic.**

6.44.28.1. Flying Classes II and III.

6.44.28.1.1. Adiposogenital dystrophy (Frohlich's syndrome).

6.44.28.1.2. Adrenal dysfunction of any degree, including pheochromocytoma.

6.44.28.1.3. Cretinism.

6.44.28.1.4. Diabetes insipidus.

6.44.28.1.5. Diabetes mellitus. (See **note** at 5.2.16.5. for diagnostic criteria). **Note**: Gestational diabetes is not specifically disqualifying; however, these aircrew members are at increased risk of subsequent development of diabetes mellitus and should be closely followed.

6.44.28.1.6. Gigantism or acromegaly.

6.44.28.1.7. Thyroid disorders.

6.44.28.1.7.1. Goiter, if associated with pressure symptoms, or if enlargement is of such degree as to interfere with wearing of a military uniform or military equipment.

6.44.28.1.7.2. Hyperthyroidism or thyrotoxicosis.

6.44.28.1.7.3. Thyroiditis, acute and subacute.

6.44.28.1.7.4. Hypothyroidism.

6.44.28.1.8. Gout.

6.44.28.1.9. Hyperinsulinism, confirmed, symptomatic.

6.44.28.1.10. Parathyroid dysfunction.

6.44.28.1.11. Hypopituitarism.

6.44.28.1.12. Myxedema, spontaneous or postoperative, with clinical manifestations.

6.44.28.1.13. Nutritional deficiency diseases (including beriberi, pellagra, and scurvy) which are more than mild and not readily amenable to therapy, or in which permanent pathological changes have been established.

6.44.28.1.14. Other endocrine or metabolic disorders which obviously preclude satisfactory performance of military service, or which require frequent or prolonged treatment.

6.44.28.1.15. Hypercholesterolemia requiring use of medication other than single approved statin or resin binder for control, or requiring multiple medications for control. See Aircrew Approved Medications list and Aircrew Waiver Guide.

6.44.28.1.16. Osteopenia.

6.44.28.1.17. Hypoglycemia from any endogenous source.

6.44.28.2. Flying Classes I and IA. In addition to **6.44.28.1**

6.44.28.2.1. Diabetes mellitus (for diagnostic criteria see note in **5.2.16.5**) Persistent glucosuria from any cause, including fasting renal glucosuria is disqualifying. Glucosuria post-prandially, or during glucose loading challenge, is not disqualifying in the absence of any renal disease, or history of recurrent genitourinary infections. However, this finding requires evaluation.

6.44.28.2.2. Any confirmed (repeated) serum fasting LDL cholesterol in excess of 190 mg/dl in association with one or no cardiac risk factor, or in excess of 160 mg/dl in association with two or more cardiac risk factors, is disqualifying.

6.44.29. **Standing Height, Sitting Height and Weight.** Height waivers may be considered for Flying Class (FC) I applicants. This is a special program administered by AETC/SGPS in coordination with AETC/DO, AETC/XP and the ACS.

6.44.29.1. **Standing Height**

6.44.29.1.1. **Flying Class I.**

6.44.29.1.1.1. Height less than 64 inches, or more than 77 inches.

6.44.29.1.2. **Flying Classes IA and Initial II (Flight Surgeon).**

6.44.29.1.2.1. Height less than 64 inches or more than 77. Waivers may be considered by weapons system.

6.44.29.1.3. **Flying Class II/III.**

6.44.29.1.3.1. Height less than 64 inches or more than 77 inches. Waivers may be considered when appropriate based on crew position. **Note**: Weapons Controllers/Directors, Combat Control, Pararescue and Air Battle Managers have no standard.

6.44.29.1.3.2. Minimum functional reach for aeromedical evacuation duties is 76 inches, regardless of height.

6.44.29.2. **Sitting Height.**

6.44.29.2.1. **Flying Class I.**

6.44.29.2.1.1. Sitting height greater than 40 inches or less than 34 inches. (See physical examination techniques for method of measurement.)

6.44.29.2.1.2. Buttock to knee measurement no greater than 27 inches. (See

physical examination techniques for method of measurement.)

6.44.29.2.2. **Flying Classes IA and Initial II (Flight Surgeon).**

6.44.29.2.2.1. Sitting height greater than 40 inches or less than 33 inches. (See physical examination techniques for method of measurement.)

6.44.29.3. **Weight**

6.44.29.3.1. **Flying Class I/IA and Initial FCII (Flight Surgeon) and Initial FCIII.**

6.44.29.3.1.1. For initial qualification members must meet fitness standards IAW AFI 10-248.

6.44.29.3.1.2. Additional standard applies for duties in ejection seat aircraft; in no case may weight be less than 103 lbs or greater than 240 lbs for T-38 and 245 lbs for all other ejection seat aircraft. Weights are unclothed (nude) body weight. **Note:** For UPT students, fighter-track UNT students and trained ejection seat aircrew identified outside of the weight for ejection seat standard, notify Squadron/CC via AF Form 1042 action.

6.44.29.3.2. **Flying Class II/III**

6.44.29.3.2.1. For trained personnel in ejection seat aircraft. Weight may not be less than 103 lbs or greater than 240 lbs for T-38 and 245 lbs for all other ejection seat aircraft. Weights are unclothed (nude) body weight.

6.44.29.3.2.1.1. Any aircrew member assigned to ejection seat aircraft who has failed to attain/maintain weight within the ejection seat standard will be placed DNIF and referred to the Squadron/CC for appropriate administrative action.

6.44.30. **Systemic and Miscellaneous Causes for Rejection.**

6.44.30.1. Flying Classes II and III.

6.44.30.1.1. Any episode of decompression sickness (DCS) or arterial gas embolism (AGE), which produces residual symptoms after completion of all indicated treatment, or persists for greater than 2 weeks. See aircrew waiver guide.

6.44.30.1.1.1. All episodes of DCS/AGE require a minimum of 72 hours DNIF after completion of treatment.

6.44.30.1.1.2. Consult base SGP and USAFSAM Hyperbaric Medicine on all cases of acute DCS/AGE.

6.44.30.1.1.2.1. DCS without neurological involvement, that resolves completely within two weeks may be RTFS by local flight surgeon after consultation with base SGP and USAFSAM Hyperbarics and MAJCOM/SGPA.

6.44.30.1.1.2.2. DCS/AGE with neurological involvement may be RTFS only after complete resolution is confirmed by neurologist or USAFSAM hyperbaricist exam, and after consultation with USAFSAM Hyperbarics and

MAJCOM/SGPA. In these cases, no waiver is required.

6.44.30.1.1.2.3. DCS/AGE cases with persistent residual symptoms require complete evaluation and MAJCOM waiver. **Note:** Previous episodes of DCS/AGE do not modify or change requirements noted.

6.44.30.1.2. Malignancies. History, or presence of, malignant tumor, cyst or cancer of any sort. Basal cell and squamous cell carcinomas and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which have been treated by electrodessication and curettage by a dermatologist credentialed to perform this procedure), are exempted from tumor board action, but are reported to tumor registry, and are not disqualifying. Childhood malignancy considered cured may be considered for waiver on a case-by-case basis. See waiver guide for waiver of underlying disease and treatment.

6.44.30.1.3. Benign tumors which interfere with function or the wear of equipment, and tumors which are likely to enlarge or be subjected to trauma during military service or show malignant potential.

6.44.30.1.4. Bone marrow donation. See aircrew waiver guide for further guidance. **Note:** Please refer to AFI 44-102, *Medical Care Management* and AFI 36-3003, *Military Leave Program*, for additional information on organ donor donation.

6.44.30.1.5. Airsickness in flying personnel is not cause for medical disqualification unless there is medical evidence of organic or psychiatric pathology. Flying personnel must be entered into the Airsickness Management Program IAW AETCI 48-102, to be given an opportunity to overcome in flight airsickness.

6.44.30.1.5.1. Flying personnel that have completed undergraduate flying training and airsickness is of such chronicity, or severity, as to interfere with the performance of flying duties will be referred to a Flying Evaluation Board to assess their potential for further flying duties, see AFI 11-402. Copies of these cases are sent through medical channels to MAJCOM/SG for review before convening a board.

6.44.30.1.5.2. Continued airsickness by students enrolled in undergraduate flying training courses, after completing the Airsickness Management Program, is medically disqualifying, if it is of such severity or chronicity as to interfere with the performance of flying duties. Final determination of medical qualification in these cases is made by MAJCOM/SG. **Note**: Pilots undergoing any phase of treatment for airsickness will not fly solo while using pharmacologic medications. Initial or undergraduate flying training is generally any formal flying training that leads to award of an AF aeronautical rating, CEA designation, or initial aircrew qualification.

6.44.30.1.6. Any allergic condition which requires desensitization therapy. Waivers are considered if symptoms are controlled by desensitization or in combination with approved medication see “Official Air Force Approved Aircrew Medications”, updated periodically by AFMSA (approved by AF/SG3P). **Note:** Aircrew will not deploy on immunotherapy. When immunotherapy is contemplated, this restriction must be considered by the treating flight surgeon.

6.44.30.1.7. Eosinophilic granuloma.

6.44.30.1.8. Gaucher's disease.

6.44.30.1.9. Schuller-Christian disease.

6.44.30.1.10. Letterer-Siwe's disease.

6.44.30.1.11. Chronic metallic poisoning.

6.44.30.1.12. Residual of cold injury, such as deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, ankylosis, amputation of any digit, or cold urticaria.

6.44.30.1.13. Heat pyrexia (heat stroke or heat exhaustion) if a reliable history indicates an abnormally lowered heat tolerance threshold.

6.44.30.1.14. History of malignant hyperthermia.

6.44.30.1.15. Syphilis, congenital or acquired. A history of primary or secondary syphilis is not disqualifying provided:

6.44.30.1.15.1. The examinee has no symptoms of disease.

6.44.30.1.15.2. There are no signs of active disease, and no residual thereof.

6.44.30.1.15.3. Serologic Venereal Disease Research Laboratory (VDRL) testing rules out reinfection.

6.44.30.1.15.4. There is a verified history of adequate treatment.

6.44.30.1.15.5. There is no evidence or history of CNS involvement.

6.44.30.1.16. Parasitic infestation, all types until adequately treated.

6.44.30.1.17. History of food-induced anaphylaxis.

6.44.30.1.18. Other congenital or acquired abnormalities, defects or diseases which preclude satisfactory performance of flying duty.

6.44.30.1.19. Miscellaneous conditions such as porphyria, hemochromatosis, and amyloidosis.

6.44.30.1.20. Inflammatory idiopathic diseases of connective tissue.

6.44.30.1.21. Lupus erythematosus (acute, subacute, or chronic).

6.44.30.1.22. Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

6.44.30.1.23. Sarcoidosis.

6.44.30.2. Flying Classes I and IA. In addition to **6.44.30.1.1** to **6.44.30.1.23**

6.44.30.2.1. Motion sickness experienced in aircraft, automobiles, or watercraft after the age of 12 with any significant frequency. Any history of motion sickness is completely explored.

Section 6H— Unmanned Aircraft System Medical Standards

6.45. RPA pilot Medical Standards. These standards apply to pilots of large (Group 4 or 5) RPA systems IAW Joint Concept of Operations for RPA systems. All members must meet retention standards as outlined in Section 5B and the following additional criteria. **Note**: For SUAS-O see 6.48.11.

Aircrew who are previously trained in another weapons system and are temporarily performing RPA only pilot duties will be held to FCIIU standards below for the duration of their RPA assignment.

When a crewmember receives care by a non-flight surgeon provider, the member must be seen by a flight surgeon for appropriate aeromedical disposition prior to resuming RPA duties. If a flight surgeon is not immediately available, the member will be removed from RPA duties until seen by a flight surgeon or the visit has been reviewed by a flight surgeon.

6.45.1. **Head.** History of head injury is managed as per **6.44.23.1.6**

6.45.2. **Ear, Nose, and Throat.**

6.45.2.1. Any disease or malformation of the nose, mouth, pharynx or larynx that might interfere with enunciation or clear voice communication.

6.45.3. **Hearing.**

6.45.3.1. For an initial FCIIU an H-1 is required. Any hearing which exceeds H-1 requires a waiver.

6.45.3.2. For continued FCIIU duties H-2 profile does not require a waiver. However, an evaluation sufficient to rule-out conductive or retrocochlear pathology must be conducted. This includes full audiologic evaluation and, where appropriate, referral for Ear, Nose, and Throat (ENT) consultation. Referral to ENT may be at the discretion of the audiologist or referring facility. Restriction from RPA duties is not required during work-up.

6.45.3.3. For crewmembers with new H-3 profiles (e.g., those whose hearing has recently changed to H-3 and who have not been previously evaluated), restriction from FCIIU duties is appropriate. An interim waiver may be granted by MAJCOM/SG after determination of acceptable hearing proficiency (e.g., occupational hearing assessment), pending complete audiological evaluation. **Note:** Crewmembers with long-standing, stable H-3 profiles not previously evaluated by an audiologist, otolaryngologist, or both require work-up and waiver, but need not be restricted from FCIIU duties, unless in the opinion of the flight surgeon they represent a danger to flight safety.

6.45.3.4. For crewmembers actively engaged in FCIIU duties, validate hearing proficiency in one of two ways prior to issuance of a medical waiver for H-3 profile:

6.45.3.4.1. A functional hearing assessment in the ground control station environment using the procedures described in physical examination techniques. If the crewmember could potentially perform duties in a multi-aircraft control ground station, the hearing assessment must be conducted in this environment.

6.45.3.4.2. Written validation, signed by the flying squadron commander or operations officer, of the adequacy of the member's hearing to perform safely in assigned FCIIU duties in the ground control station environment must be

supplemented by the assigned flight surgeon's written memorandum for record stating that speech discrimination levels, according to the audiologist's examination, are adequate for the performance of RPA duties.

6.45.3.5. Asymmetric hearing loss (as evidenced by a 25 (dB or greater difference between the left and right ears at any two consecutive frequencies) requires full audiological work-up with further clinical evaluation as indicated, and requires a waiver (indefinite waivers are not authorized). Restriction from FCIIU duties is not required during work-up.

6.45.3.6. The following tests are suggested as a complete audiological evaluation:

6.45.3.6.1. Pure tone air and bone conduction thresholds.

6.45.3.6.2. Speech reception thresholds.

6.45.3.6.3. Speech discrimination testing, to include high intensity discrimination.

6.45.3.6.4. Immittance audiometry.

6.45.3.6.5. Tympanograms.

6.45.3.6.6. Ipsilateral and contralateral acoustic reflexes (levels not exceeding 110 dB hearing level (HL)).

6.45.3.6.7. Acoustic reflex decay (500 and 1000 Hertz (Hz), with levels not exceeding 110 dB HL).

6.45.3.6.8. Otoacoustic emissions (transient evoked or distortion product).

6.45.3.7. The following tests may be required if indicated by those listed above.

6.45.3.7.1. Auditory brainstem response.

6.45.3.7.2. MRI.

6.45.4. **Eye.**

6.45.4.1. Lids/adnexa. Any condition of the eyelids which impairs normal eyelid function or comfort, or potentially threatens visual performance, including, but not limited to epiphora, inflammation or obstruction of the nasolacrimal apparatus, and ptosis.

6.45.4.2. Conjunctiva.

6.45.4.2.1. Current conjunctivitis, including, but not limited to trachoma and chronic allergic conjunctivitis.

6.45.4.2.2. Xerophthalmia.

6.45.4.3. Cornea.

6.45.4.3.1. Current or history of keratitis, including, but not limited to recurrent corneal ulcers or corneal erosions.

6.45.4.3.3. Corneal dystrophy of any type to include keratoconus of any degree.

6.45.4.4. Uveal tract. Acute, chronic, or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid) except for healed traumatic iritis.

6.45.4.5. Lens.

6.45.4.5.1. Opacities, cataracts, or irregularities of the lens, which interfere with vision or are considered to be progressive.

6.45.4.6. Retina.

6.45.4.6.1. Current or history of retinal defects and dystrophies, angiomatoses, retinoschisis and retinal cysts, phakomatoses, and other congenito-retinal hereditary conditions that impair visual function or are progressive.

6.45.4.6.2. Current or history of any chorioretinal or retinal inflammatory conditions.

6.45.4.6.3. Current or history of degenerative changes to any part of the retina.

6.45.4.6.4. Current or history of detachment of the retina, history of surgery for the same or peripheral retinal injury, defect, or degeneration that may cause retinal detachment.

6.45.4.6.5. Current or history of hemorrhages, exudates, or other retinal vascular disturbances.

6.45.4.7. Optic nerve.

6.45.4.7.1. Current or history of optic neuritis, including, but not limited to neuroretinitis, papillitis, and retrobulbar neuritis.

6.45.4.7.2. Current or history of optic atrophy (primary or secondary) or cortical blindness.

6.45.4.7.3. Current or history of papilledema.

6.45.4.7.4. Optic nerve cupping greater than 0.4 or an asymmetry between the cups of greater than 0.2, unless proven to be physiologic after comprehensive evaluation by an eye care specialist. This evaluation must include local diurnal pressure checks and visual field testing.

6.45.4.7.5. Current or history of optic neuropathy.

6.45.4.7.6. Optic nerve head drusen.

6.45.4.8. Ocular motility.

6.45.4.8.1. Current or history of diplopia in any field of gaze, either constant or intermittent.

6.45.4.8.2. Nystagmus, except at versional end points.

6.45.4.8.3. Absence of conjugate alignment in any quadrant.

6.45.4.8.4. Current or history of extraocular muscle paralysis or paresis with loss of ocular motility in any direction.

6.45.4.8.5. History of extraocular muscle surgery or strabismus therapies.

6.45.4.8.6. Esophoria greater than 10 prism diopters at near or distance.

6.45.4.8.7. Exophoria greater than 6 prism diopters at near or distance.

6.45.4.8.8. Hyperphoria greater than 1.5 prism diopters at near or distance.

6.45.4.8.9. Heterophorias, including microtropias, at near or distance

6.45.4.8.10. Point of convergence greater than 100 mm.

6.45.4.9. Miscellaneous defects and diseases.

6.45.4.9.1. Monocularity.

6.45.4.9.2. Current asthenopia that impacts ability to perform aircrew duties or interferes with personal safety or PPE.

6.45.4.9.3. Current or history of increased intraocular pressure.

6.45.4.9.3.1. Glaucoma as evidenced by intraocular pressure of 30 mm Hg or greater or the secondary changes in the optic disc or visual field associated with glaucoma.

6.45.4.9.3.2. Ocular hypertension (preglaucoma) as evidenced by two or more intraocular pressure determinations of 22 mm Hg or greater but less than 30 mm Hg, or a difference of 4 mm Hg or greater between the two eyes. **Note:** Abnormal pressures obtained by noncontact (air puff) tonometer of Schiotz must be verified by applanation.

6.45.4.9.4. Current loss of normal pupillary reflex or reactions to accommodation or light with the exception of physiological anisocoria.

6.45.4.9.5. Current or history of retained intraocular foreign body.

6.45.4.9.6. Any traumatic, organic, or congenital disorder of the eye or adnexa which threatens, or potentially threatens, to intermittently or permanently impair visual function.

6.45.4.9.7. History of refractive or other ocular surgery to include lasers of any type. Waivers may be considered for refractive surgery (refer to USAF Aviation Refractive Surgery Website at **http://www.brooks.af.mil/web/consult_service/opto_sect/crs.htm**?). **Note**: For initial selection, applicants must be at least 12 months from their surgery date.

6.45.5. **Vision.**

6.45.5.1. Corrected distant vision worse than 20/20 in each eye.

6.45.5.2. Corrected near vision worse than 20/20 in each eye.

6.45.5.3. Contact lenses that only correct near visual acuity, are bifocal or multifocal, or are fit with monovision techniques.

6.45.5.4. Optional wear of contact lenses is in accordance with the USAF Aircrew Soft Contact Lens Policy per **Section 6F**.

6.45.5.5. Crewmembers who wear corrective spectacles or contact lenses must carry a spare set of prescription spectacles on their person while performing RPA duties.

6.45.6. **Color Vision.**

6.45.6.1. Initial selection. Color vision deficit or anomaly of any degree or type.

6.45.6.1.1. All initial applicants must pass definitive color vision testing. Definitive color testing consists of the following tests approved by AF/SG.

6.45.6.1.1.1. Pseudo-Isochromatic Plates (PIP) I (minimum passing score 12/14 OU tested monocularly).

*__Note__: All USAFA and ROTC cadets receiving initial flight physicals during the 2009-2010 academic year will be held to the 10/14 PIP I standards. For the purposes of this AFI, the academic year will end 1 Jul 2010.

6.45.6.1.1.2. PIP II (minimum passing score 9/10 each eye, tested monocularly).

6.45.6.1.1.3. F2 pass or fail (able to correctly identify number, location and orientation of squares, tested monocularly.

6.45.6.1.1.4. Confirmatory testing by the ACS on any history of color screening test failure, to include Anomaloscope and Cone Contrast Test, may be required.

6.45.6.2. Trained assets. Must possess normal color vision as demonstrated by annually passing approved Air Force color vision test(s).

6.45.6.2.1. Trained assets that fail the PIP I and were previously qualified for flying or RPA duties based on a history of passing a PIP 1 with 10/14 or FALANT and/or the Color Threshold Tester (CTT) require a waiver. A formal ophthalmologic evaluation must be accomplished to determine the type and degree of color vision defect. The crewmember will be limited to their current ground control station (GCS) unless a functional assessment has been devised for the new GCS.

6.45.6.2.2. Color vision screening done at base level must be performed monocularly under an approved and standardized illuminant (e.g., MacBeth easel lamp with a 100 watt bulb or a True Daylight AE lamp from Richmond Products). Three or more incorrect responses in either eye (including failure to make responses in the allowed time interval (no more than five seconds)) in reading the 14 test plates of one of the following PIP tests is considered a failure: Dvorine, the original version of the American Optical (excludes Richmond PIP version), or Ishihara. More than one incorrect response on the PIP II (SPP2) in either eye is considered a failure. No other PIP versions, such as the Richmond PIP, Beck Engraving versions, or other tests for color vision are authorized. Test scores must be recorded as the number of correct/total number presented. The FALANT is not authorized. (Refer to USAF Waiver Guide Website at AFMS Knowledge Exchange - Waiver Guide.

6.45.7. **Visual Fields.**

6.45.7.1. Visual field defects of any type.

6.45.7.2. Central scotoma, whether active or inactive, including transitory migraine-related or any other central scotoma due to an active pathological process.

6.45.7.3. Any peripheral scotoma other than physiologic.

6.45.8. **Red Lens Test.**

6.45.8.1. Not required for trained assets. For initial selection, any diplopia or suppression during the Red Lens Test developing within 20 inches of the center of the

screen (30 degrees) is considered a failure. If failed, a complete preliminary local evaluation of ocular motility/alignment must be accomplished by a qualified ophthalmologist or optometrist as described in **6.44.11.1.1**

6.45.9. **Cardiopulmonary System.**

6.45.9.1. Any documented coronary artery disease (CAD), with or without intervention. Any abnormal noninvasive cardiac test, unless complete evaluation reveals no evidence of CAD.

6.45.9.2. Any abnormal or borderline ECG finding, unless recommended evaluation discloses no disqualifying pathology. See guidelines for disposition of ECG findings in aircrew available at AFMS Knowledge Exchange **https://kx.afms.mil/kxweb/dotmil/file/web/ctb_042805.pdf**

6.45.9.3. Any dysrhythmia or ectopy associated with hemodynamic symptoms or when symptoms may interfere with the satisfactory performance of RPA duties. Major dysrhythmias without hemodynamic symptoms. Ablation of major dysrhythmias or bypass tracts.

6.45.9.4. Symptomatic valvular heart disease. Asymptomatic valvular heart disease graded as moderate or worse.

6.45.9.5. Hypertension or history of hypertension on antihypertensive medication. Hypertension is evidenced by average systolic blood pressure greater than 140 mm Hg or average diastolic blood pressure greater than 90 mm Hg. **Note**: Asymptomatic personnel with average systolic blood pressure ranging from 141 mm Hg and 160 mm Hg, or average diastolic blood pressure ranging between 91 mm Hg and 100 mm Hg, may remain on RPA controlling status for up to 6 months (from the time the elevated blood pressure was first identified) while undergoing non-pharmacological intervention to achieve acceptable values.

6.45.9.6. Corrected patent ductus arteriosus (PDA), atrial (ASD) and ventricular (VSD) septal defects, and aortic coarctation waiver eligible if no residua. Hemodynamically insignificant ASD and VSD may be acceptable.

6.45.9.7. Current or history of any vascular thrombosis or pulmonary embolus.

6.45.10. **Blood and Blood-Forming Tissues (Bone Marrow Donation/Biopsy).**

6.45.10.1. Blood donation (including plasma and platelet donation) and immunotherapy: 4 hr restriction from FCIIU duty (formal flight surgeon restriction not required). See aircrew waiver guide for further guidance.

6.45.11. **Abdomen and Gastrointestinal System.**

6.45.11.1. Acute, recurrent, or chronic cholecystitis.

6.45.11.2. Current or history of peptic, duodenal or gastric ulcer or gastrointestinal bleeding.

6.45.11.3. Abnormalities of the bowel including, but not limited to, irritable bowel syndrome, diverticular disease, malabsorption syndromes, or chronic diarrhea of

sufficient severity to require frequent interventions or to interfere with normal functioning.

6.45.11.4. Current fecal incontinence.

6.45.12. **Female Genital and Reproductive Organs.**

6.45.12.1. Current or history of genital infection or ulceration of sufficient severity to require frequent intervention and interferes with normal functioning.

6.45.12.2. Current or history of dysmenorrhea that is incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.

6.45.12.3. Current or history of endometriosis, ovarian cysts, or chronic pelvic pain when symptoms are severe and interfere with normal functioning.

6.45.12.4. Current pelvic inflammatory disease.

6.45.12.5. Any traumatic, organic, or congenital disorders of the genitalia of sufficient severity to cause distracting symptoms, require frequent intervention, or interfere with normal functioning.

6.45.12.6. Pregnancy is not necessarily disqualifying from RPA duties. It may be appropriate to remove an individual from RPA duties if she is experiencing any significant side effects from her pregnancy.

6.45.13. **Male Genitalia.**

6.45.13.1. Current or history of genital infection or ulceration of sufficient severity to require frequent intervention and interferes with normal functioning.

6.45.13.2. Current hydrocele, unless small and asymptomatic.

6.45.13.3. Large or painful left varicocele. Any right varicocele unless significant underlying pathology has been excluded.

6.45.13.4. Current acute or chronic orchitis or epididymitis if causing severe symptoms or interferes with normal function.

6.45.13.5. Current or history of chronic scrotal pain.

6.45.13.6. Chronic prostatitis or prostatic hypertrophy with urinary retention or abscess of the prostate gland.

6.45.13.7. Any traumatic, organic, or congenital disorders of the genitalia of sufficient severity to cause distracting symptoms, require frequent intervention, or interfere with normal functioning.

6.45.14. **Urinary System.**

6.45.14.1. Acute, recurrent, or chronic urinary tract diseases causing severe symptoms or interfering with normal function, including, but not limited to urethritis and cystitis.

6.45.14.2. Current incontinence of urine.

6.45.14.3. Current urethral stricture, fistula, or cystostomy.

6.45.14.4. Current hematuria, pyuria, proteinuria (greater than 200 mg/24 hrs; or a protein to creatinine ratio greater than 0.2 in a random urine sample, if greater than 48 hours after strenuous activity), or other findings indicative of urinary tract disease unless consultation determines the condition to be benign.

6.45.14.5. Current urolithiasis or history of recurrent calculus, nephrocalcinosis, retained extraparenchymal calculus, or bilateral renal calculi.

6.45.14.5.1. Uncomplicated single episode of renal calculus does not require waiver, but must be evaluated.

6.45.14.6. Renal ptosis (floating kidney) causing impaired renal drainage or pain.

6.45.14.7. Current or history of horseshoe kidney.

6.45.14.8. Current neurogenic bladder.

6.45.14.9. History of renal transplant.

6.45.14.10. Any traumatic, organic, or congenital disorders of the urinary tract of sufficient severity to cause distracting symptoms, require frequent intervention, or interfere with normal functioning.

6.45.15. **Endocrine.**

6.45.15.1. Current or history of adrenal, pituitary, parathyroid, thyroid, or nutritional disease unless asymptomatic, the underlying condition has been corrected, and there is no residual.

6.45.15.2. Current or history of gout.

6.45.15.3. Diabetes mellitus (for diagnostic criteria see note in **5.3.16.5**).

6.45.16. **Neurological Disorders.**

6.45.16.1. History of any disturbance of consciousness (not due to head injury).

6.45.16.1.1. An isolated episode of neurocardiac syncope associated with venipuncture or similar benign precipitating event which is less than 1 minute in duration, without loss of continence, and followed by rapid and complete recovery without sequelae does not require waiver if a thorough neurological and cardiovascular evaluation by a flight surgeon reveals no abnormalities.

6.45.16.2. Electroencephalographic abnormalities.

6.45.16.2.1. Benign transients such as Small Sharp Spikes (SSS) or Benign Epileptiform Transients (BETS), wicket spikes, 6 Hz (phantom spike and wave, rhythmic temporal theta of drowsiness (psychomotor variant), and 14 and 6 Hz positive spikes are not disqualifying.

6.45.16.3. Current or history of any of the following types of headaches:

6.45.16.3.1. Recurrent primary headaches, including, but not limited to migraine, tension type, and cluster headaches with any of the following characteristics:

6.45.16.3.2. Impairment in social, vocational or academic activities caused by the headache, its associated symptoms, or both.

6.45.16.3.3. Medication other than over-the-counter analgesics is required for abortive control of the headache.

6.45.16.3.4. A prescription for prophylactic medication is required to control the headache.

6.45.16.3.5. There is neurological dysfunction or deficit including aura, with or without (e.g., acephalgic migraine) associated headache.

6.45.16.3.6. A secondary headache meeting any of the above criteria unless both the headache and its underlying cause(s) have resolved.

6.45.16.4. Current or history of vertigo or disequilibrium disorders.

6.45.16.5. Current or history of cerebrovascular conditions, including, but not limited to subarachnoid or intracerebral hemorrhage, vascular insufficiency, aneurysm, arteriovenous malformation, or cerebrovascular infarct.

6.45.16.6. Current or history of acute infectious process of the central nervous system or neurosyphilis of any form.

6.45.16.7. Current or history of paralysis, weakness, lack of coordination, chronic pain, or sensory disturbance, including but not limited to multiple sclerosis and Parkinson's disease.

6.45.16.8. Sleep disorders to include, but not limited to, sleep apneas, insomnias, hypersomnias, narcolepsy, or restless leg syndrome.

6.45.17. **Learning, Psychiatric, and Behavioral.** (Reference current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association)

6.45.17.1. Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder or Perceptual/Learning Disorder(s), unless the individual can demonstrate passing academic performance and there has been no use of medication(s) in the past 12 months.

6.45.17.2. Current or history of eating disorder.

6.45.17.3. Current or history of alcohol dependence, drug dependence, alcohol abuse, drug abuse, or any other substance-related disorders. Alcohol dependence and abuse may be waived in accordance with the requirements in **6.44.24.1.5**

6.45.17.4. Current or history of schizophrenia or other psychotic disorder.

6.45.17.5. Current or history of mood disorder including, but not limited to, major depressive disorder, dysthymic disorder, cyclothymic disorder, depressive disorder not otherwise specified, and bipolar disorder.

6.45.17.6. Current or history of anxiety disorder including, but not limited to, generalized anxiety disorder, phobic disorders, obsessive-compulsive disorder, posttraumatic stress disorder, and acute stress disorder.

6.45.17.7. Current or history of dissociative disorder.

6.45.17.8. Current or history of somatoform disorders including, but not limited to, hypochondriasis or pain disorder.

6.45.17.9. Gender identity disorder.

6.45.17.10. Sexual dysfunctions and sexual disorders not otherwise specified are not medically disqualifying unless in association with another Axis I disorder.

6.45.17.11. Sexual paraphilias are not medically disqualifying; however, individuals meeting diagnostic criteria are dealt with administratively.

6.45.17.12. Current adjustment disorder of more than 60 days duration.

6.45.17.13. Psychological factors affecting a medical condition.

6.45.17.14. Mental disorder due to a general medical condition.

6.45.17.15. Current or history of delirium, dementia, amnestic, and other cognitive disorder.

6.45.17.16. Sleep disorders of such magnitude to warrant somatic treatment greater than 30 days duration, or if associated with an Axis I disorder other than adjustment disorder.

6.45.17.17. Current or history of factitious disorder.

6.45.17.18. Current or history of impulse control disorder.

6.45.17.19. Unsatisfactory adaptability rating for RPA duties (AR-RPA). Maladaptive personality traits (not meeting diagnostic criteria for a personality disorder), or a pattern of maladaptive behavior that significantly interferes with safe RPA operation, crew coordination, or mission completion. In the absence of maladaptive personality traits or behavior patterns, motivational issues are managed administratively.

6.45.17.20. Personality disorder severe enough to repeatedly manifest itself by significant interference with safe RPA operation, crew coordination, or mission completion; but cannot be used as a medical reason for separation from active duty. See also 5.3.12.3.

6.45.17.21. History of suicidal behavior including gesture(s) or attempt(s), or history of self mutilation.

6.45.17.22. Current or history of a mental disorder that, in the opinion of the flight surgeon, shall interfere with, or prevent satisfactory performance of military duties.

6.45.18. **Spine and Musculoskeletal.**

6.45.18.1. Current conditions including, but not limited to, the spine and sacroiliac joints associated with local or referred pain to the extremities, muscular spasms, postural deformities, requires external support, requires frequent treatment, or prevents satisfactory performance of duties.

6.45.18.2. Current disease, injury, or congenital condition with residual weakness or symptoms such as to require frequent treatment or prevent satisfactory performance of duties including, but not limited to, chronic bone and joint pain.

6.45.19. **Additional Testing.**

6.45.19.1. HIV antibody and RPR testing is required for all applicants for initial duty, as well as those returning to active duty as discussed in section 3.1.7.

6.45.19.2. An AR-RPA and a reading aloud test (RAT) are required for all applicants for initial duty.

6.45.20. **Medication.**

6.45.20.1. For flying class IIU. Use of any medication is prohibited, except as described in the "Official Air Force Approved Aircrew Medication" updated periodically by AFMSA (approved by AF/SG3P).

6.45.20.2. Use of any Over the Counter (OTC) Medications is prohibited, except as described in the "Official Air Force Aproved Aircrew Medications Over the Counter (OTC) Medications", updated periodically by AFMSA (approved by AF/SG3P).

6.45.21. **Miscellaneous.**

6.45.21.1. Malignancies. History or presence of malignant tumor, cyst, or cancer of any sort. Basal cell and squamous cell carcinomas and carcinoma-in-situ of the cervix which have been adequately excised (as evidenced by pathology report, or basal cell carcinoma which have been treated with electrodessication and curettage by a dermatologist credentialed to perform this procedure) are not disqualifying. Childhood malignancy considered cured may be considered for waiver on a case-by-case basis.

6.45.21.2. Benign tumors which interfere with function are likely to enlarge or be subjected to trauma during military service, or shown malignant potential.

6.45.21.3. Other congenital or acquired abnormalities, defects, or diseases which preclude safe and satisfactory performance of RPA duties.

Section 6I— Ground Based Aircraft Controller

6.46. Ground Based Aircraft Controller Medical Standards. The standards in Section 6I apply to all ground based aircraft controllers which includes air traffic controller, weapons controllers/directors, combat controllers and Aerospace Control and Warning Systems (1C5X1), Tactical Air Control Party (1C4X1), Air Liaison Officer (13LX) and RPA sensor operators (1U0X1). Conditions in Chapter 5, Continued Military Service (Retention Standards) or WWD standards also apply. For conditions listed in Chapter 5, ensure an MEB has been performed and final disposition made prior to submission of a waiver request.

In addition to the standards in Section 6I, Combat Controllers must also meet the relevant Section 6K categories. Air Battle Managers, Air Weapons Controllers/Directors, required to perform frequent and regular aerial flights must also meet Flying Class III standards in Section 6G. Pararescuemen must also meet standards in Section 6K.

The medical conditions listed in Chapter 5, Section 6G and relevant Section 6K 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, *Medical Recommendation for Flying or Special Operational Duty*, IAW Section 6C. **Note**: These standards do not apply to: Small unmanned aircraft systems operators (SUAS-Os). (See Section 6K 6.48.11.).

6.46.1. **Ear, Nose, and Throat.**

6.46.1.1. Symptomatic allergic rhinitis, seasonal or perennial not controlled by use of a single approved medication.

6.46.1.2. Any disease or malformation of the nose, mouth, pharynx or larynx that might interfere with enunciation or clear voice communication.

6.46.1.3. Any disturbance of equilibrium.

6.46.1.4. Obstructions of the nose from any cause which prevent nasal respiration.

6.46.2. **Hearing.**

6.46.2.1. Hearing loss greater than that specified for H-1 profile for initial selection. Hearing loss greater than that specified for H-2 profile for continued controller duty.

6.46.2.2. Use of hearing aid.

6.46.3. **Eye.**

6.46.3.1. Monocularity.

6.46.3.2. Intraocular pressure.

6.46.3.2.1. Glaucoma, as evidenced by pressure of 30 mmHg or greater, or the secondary changes in the optic disc or visual field associated with glaucoma.

6.46.3.2.2. Ocular hypertension (preglaucoma). Two or more determinations of 22 mmHg or greater but less than 30 mmHg, or a difference of 4 mmHg or greater between the two eyes.

6.46.3.3. Nystagmus, except on versional end points.

6.46.3.4. Contact lenses that correct near visual acuity only or that are bifocal, or that are fit with the monovision techniques.

6.46.3.5. Diplopia in any field of gaze, either constant or intermittent, including history of.

6.46.3.6. History of approved keratorefractive surgery procedures, including PRK, LASEK, epi-LASIK, and LASIK accomplished to modify the refractive power of the cornea are disqualifying if the surgical outcome results in the member's inability to meet established vision standards or interferes with the member's ability to perform his/her duties. All other lamellar keratoplasty (LK), penetrating keratoplasty (PK), and RK procedures are disqualifying, regardless of visual outcome.

6.46.3.7. Extraocular muscle paralysis or paresis with loss of ocular motility in any direction.

6.46.3.8. Absence of conjugate alignment in any quadrant.

6.46.4. **Vision.**

6.46.4.1. Distant uncorrected, worse than 20/400 each eye.

6.46.4.2. Distant or near vision that is not correctable to 20/20 each eye.

6.46.4.3. Near uncorrected, no standard. **Note**: Stabilized visual acuity below the above level is disqualifying; this includes following refractive surgery. Refractive surgical outcomes that interfere with the member's ability to perform his/her duties are also disqualifying. Some occupations, such as combat controllers, must also meet flying class III standards; therefore, approved refractive surgery procedures require waiver processing because these procedures are disqualifying for the AASD career fields.

6.46.5. **Heterotropias and Heterophorias.**

6.46.5.1. Any heterotropia.

6.46.5.2. Heterophorias. More than 1.5 prism diopter of hyperphoria, 10 prism diopters of esophoria, or 6 prism diopters of exophoria requires a thorough evaluation for other eye pathology motor and sensory abnormalities, by an optometrist or ophthalmologist. Section **6G, 6.44.11** applies.

6.46.6. **Defective Color Vision.** Color vision testing must be performed annually and recorded monocularly under approved and standardized illuminant (i.e., MacBeth easel lamp with a 100 watt light bulb or a True Daylight AE lamp from Richmond Products). Three or more incorrect responses in either eye (including failure to make responses in the allowed time interval (no more than 5 seconds), using either the Dvorine or Ishihara (14 test plate version) PIP I, is considered a failure. The same testing conditions and time intervals apply for the PIP II. The minimum passing score on the PIP II is no more than one incorrect response. No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other PIP tests for color vision are authorized. The FALANT is not authorized.

Note: All other ground based aircraft controllers who were previously qualified for controlling duties based on the previous 10/14 PIP I and fail the new 12/14 PIP I standard will be considered for waiver in their current weapon system or AFSC after appropriate evaluation. A formal ophthalmologic evaluation must be accomplished to determine the type and degree of color vision defect.

6.46.7. **Depth Perception.** No standard except for career fields below:

6.46.7.1. Tactical Air Control Party (1C4X1), Air Liaison Officer (13LX). Failure of either the Vision Test Apparatus (VTA-DP), or its newer replacement, the OVT is considered disqualifying if the failure occurs with best corrected visual acuity regardless of level of uncorrected visual acuity.

6.46.7.2. Failure of the VTA or OVT stereopsis testing requires completion of a local preliminary ocular motility and macular examination by an ophthalmologist or optometrist, and review by both AETC and the ACS. The testing must be accomplished as listed in **6.44.11.1.1**

6.46.8. **Visual Fields.** Any visual field defect.

6.46.9. **Night Vision.** Unsatisfactory night vision as determined by history for initial controller duty. In trained controllers, this history is confirmed, when clinically required, by the appropriate electrophysiological tests requested by the Aeromedical Consultation Service ophthalmologists.

6.46.10. **Cardiovascular System.**

6.46.10.1. History of myocardial infarction, angina pectoris, or other evidence of coronary heart disease including silent ischemia.

6.46.10.2. History of dysrhythmia with symptoms of hemodynamic compromise.

6.46.10.3. Symptomatic valvular heart disease or asymptomatic moderate to severe valvular disease associated with hypertrophy, chamber enlargement, or ventricular dysfunction (see **Chapter 5**).

6.46.10.4. Aneurysm or AV fistula of a major vessel.

6.46.10.5. Hypertension, or history of hypertension on antihypertensive medication. Hypertension is evidenced by average systolic blood pressure greater than 140 mmHg or average diastolic blood pressure greater than 90 mmHg. Patients may be followed initially as in **6.44.17**

6.46.10.6. Resting pulse rate greater than 110 or less than 45 beats per minute.

6.46.10.7. ECG evidence of significant conduction defects, to include Wolff-Parkinson-White syndrome.

6.46.11. **Blood, Blood-forming Tissues, and Immune System.**

6.46.11.1. Anemia of any etiology.

6.46.11.2. Blood donation (including plasma and platelet donation): 8 hr restriction from controller duty (formal flight surgeon restriction not required).

6.46.12. **Abdomen and Gastrointestinal System.**

6.46.12.1. Gastrointestinal hemorrhage or history of, regardless of cause.

6.46.12.2. Peptic ulcer disease or any complication of peptic ulcer disease. An uncomplicated ulcer that has been inactive for 3 months and does not require medication (except the occasional use of antacids) is not disqualifying.

6.46.12.3. Cholelithiasis that is symptomatic or requires ongoing therapy.

6.46.13. **Genitourinary System.**

6.46.13.1. History of recurrent or bilateral renal calculus.

6.46.13.2. Retained renal calculus, except parenchymal.

6.46.13.3. Cystostomy.

6.46.13.4. Neurogenic bladder.

6.46.13.5. Renal transplant.

6.46.14. **Neurological Disorders.**

6.46.14.1. History of any medically unexplained disturbance of consciousness or where surgical intervention was necessary to correct the precipitating cause.

6.46.14.2. History of any of the following types of headaches:

6.46.14.2.1. Recurrent headaches of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

6.46.14.2.2. A single incapacitating headache of any type (e.g., loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

6.46.14.2.3. Headaches of any type which are of sufficient severity to likely interfere with controlling duties.

6.46.14.2.4. Acephalgic migraines.

6.46.14.3. History of recurrent vertigo or dysequilibrium disorders.

6.46.14.4. Cerebrovascular disease to include transient ischemic attack (TIA), cerebral infarction, thrombotic or embolic, or transient global amnesia.

6.46.14.5. Demyelinating and autoimmune diseases.

6.46.14.6. Extrapyramidal, hereditary, and degenerative diseases of the nervous system.

6.46.14.7. Infections of the nervous system.

6.46.15. **Psychiatric Disorders.** (Reference most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association.)

6.46.15.1. Substance use disorder or any disease the proximate cause of which is substance use. Waiver may be considered when all of the requirements in **6.44.24.1.5** are met and documented.

6.46.15.2. Unsatisfactory adaptability rating for GBC duties.

6.46.15.3. Anxiety disorders. **Note:** Fear of controlling which does not meet the DSM criteria for a disorder is handled administratively.

6.46.15.4. History of attempted suicide or suicidal behavior.

6.46.15.5. Mood disorders including bipolar disorder, major depression, dysthymia and depression not otherwise specified.

6.46.15.6. All organic mental disorders.

6.46.15.7. Any personality disorder, or mental condition that may render the individual unable to safely perform controller duties. A personality disorder that is severe enough to have repeatedly manifested itself by overt acts disqualifies the individual from controller duties. Also, see **5.3.12.3.2**.

6.46.16. **Musculoskeletal, Spine, and Extremities.** Any disease, condition, or deformity of the musculoskeletal system, which may impair duty performance or access to control facilities, is likely to progress, or which requires frequent use of analgesic or anti-inflammatory medication for control.

6.46.17. **Endocrine and Metabolic.**

6.46.17.1. Diabetes insipidus.

6.46.17.2. Hypoglycemia, whether functional or a result of pancreatic tumor.

6.46.17.3. Thyroid disorders.

6.46.17.4. Other endocrine or metabolic disorders which preclude satisfactory performance of controller duties.

6.46.18. **Medication.**

6.46.18.1. Use of any medication whose known actions may affect alertness, judgment, cognition, special sensory function, mood, or coordination. See "Official Air Force Approved Aircrew Medication", updated periodically by AFMSA (approved by AF/SG3P) for list of approved medications.

6.46.19. **Miscellaneous.**

6.46.19.1. Exacerbation of any medical condition for which a waiver has been granted.

6.46.19.2. HIV antibody testing is required for all applicants for initial controller duty. Record the results of cholesterol, high-density lipoprotein (HDL), and triglycerides in item 19F or item 42, SF 88 or appropriate block in DD Form 2808.

6.46.19.3. An AR-GBC and a reading aloud test (RAT) is required on all applicants for initial controller duty. Record the results in item 41, SF 88 or item 72a, DD Form 2808. The RAT and instructions are in AFJI 36-2018, *Medical Examination of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including Two and Three-Year College Scholarship Programs (CSP), and the Uniformed Services University of Health Sciences (USUHS).*

Section 6J— Space and Missile Operations Duty (SMOD)

6.47. Space and Missile Operations Duty (SMOD) Standards. The medical conditions listed in Chapter 5 and Section 6J are cause to reject SMOD personnel for continued duty unless a waiver is granted. For conditions listed in Chapter 5, ensure an MEB or assignment limitation code fast-track request has been performed and final disposition made prior to submission of a waiver request. SMOD personnel require annual exam IAW AFI 44-170, including annual color vision testing.

The medical conditions listed in Chapter 5 and Section 6J are cause to reject an examinee for initial SMOD duty (AFSCs 13SX and 1C6XX) and any individual of another AFSC assigned to operational crew duty maintaining mission ready or equivalent status.

Acute medical problems, injuries, or their appropriate therapy can be cause for withholding certification for initial training 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 SMOD duties using AF Form 1042 IAW Section 6C.

6.47.1. **Vision.**

6.47.1.1. Defective Color Vision. Color vision screening done at base level must be performed monocularly under an approved and standardized illuminant (i.e., MacBeth easel lamp with a 100 watt light bulb or a True Daylight AE lamp from Richmond Products). Three or more incorrect responses in either eye (including failure to make

responses in the allowed time interval (no more than 5 seconds), using either the Dvorine or Ishihara (14 test plate version) PIP I, is considered a failure. The same testing conditions and time intervals apply for the PIP II. The minimum passing score on the PIP II is no more than one incorrect response. Note: Test scores must be recorded as number correct/total number presented. Documentation of results must also be recorded monocularly (Example: PIP OD: 12/14, OS: 13/14 Passes). No other PIP versions, such as Richmond PIP, or Beck Engraving versions, or other PIP tests for color vision are authorized. The FALANT is not authorized.

Note: All other SMOD personnel who were previously qualified for SMOD duties based on the previous 10/14 PIP I and fail the new 12/14 PIP I standard will be considered for waiver in their current weapon system or AFSC after appropriate evaluation. A formal ophthalmologic evaluation must be accomplished to determine the type and degree of color vision defect.

6.47.1.2. Corrected visual acuity worse than 20/20 in the better eye near and distant. **Note:** Individuals found on routine examination to be less than 20/20 in the better eye in either near or distant, or both, but correctable to at least 20/20 near and distant in one eye may continue to perform Space and Missile Operations duties until the appropriate corrective lenses arrive. These lenses must be ordered by the most expeditious means.

6.47.2. **Ears, Hearing, Vestibular System.**

6.47.2.1. A hearing profile worse than H-2 for initial selection or worse than H-3 for continued SMOD duty.

6.47.2.2. Any disturbance of equilibrium.

6.47.3. **Head and Neck.**

6.47.3.1. Any disease or malformation of the nose, mouth, pharynx, or larynx that might interfere with enunciation or clear voice communication as demonstrated by the reading aloud test.

6.47.4. **Neurological.**

6.47.4.1. Headaches.

6.47.4.1.1. Initial applicants: History of recurrent headaches of the vascular, migraine, or cluster type (including acephalgic migraines).

6.47.4.1.2. Trained personnel: Recurrent headaches of the vascular, migraine, or cluster type (including acephalgic migraines) confirmed by neurologist evaluation.

6.47.4.1.3. A single incapacitating headache of any type (i.e., loss of consciousness, aphasia, ataxia, vertigo or mental confusion).

6.47.4.2. History of seizures within the past 5 years, or usage of medications to control seizures within the past 5 years.

6.47.4.3. Head injuries.

6.47.4.3.1. Head injury of a mild degree (**See 6.44.23**) with a normal neurological examination by a flight surgeon does not require waiver action.

6.47.4.3.2. Head injury of a moderate or severe degree (**6.44.23**) will require waiver. See aircrew waiver guide.

6.47.5. **Psychiatric.** See most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), American Psychiatric Association.

6.47.5.1. Psychiatric profile other than S-1 and S-1 profile with a psychiatric diagnosis.

6.47.5.2. History of claustrophobia.

6.47.5.3. Alcohol dependence or abuse or any disease the proximate cause of which is alcoholism. Waiver may be considered when all of the requirements in **6.44.24.1.5** are met and documented.

6.47.5.4. Any psychiatric condition, or history thereof, which, in the opinion of the examining flight surgeon, would interfere with the performance of space and missile operations crew duty. Also see **5.3.12.3.2**.

6.47.5.5. Unsatisfactory AR-SMOD.

6.47.5.6. History of attempted suicide, or suicidal behavior.

6.47.6. **Medication (See Approved Space and Missile Operation Medication List on AFMSA Knowledge Junction).**

6.47.6.1. Prescription Medications.

6.47.6.1.1. Personnel may not perform SMOD Combat Mission Ready (CMR) or Basic Mission Ready (BMR) duties (AFSPCI 10-1202, *Crew Operations* paragraphs 1.3 and 1.4.) while using any medication whose known common adverse effect or intended action(s) affect alertness, judgment, cognition, special sensory function, mood or coordination.

6.47.6.1.2. CMR and/or BMR SMOD personnel prescribed medication with these known actions must be placed in DNIC or DNIA status while under their effects. If chronic or long-term use of such medications is required, a medical waiver must be accomplished and reviewed by AFSPC/SGP (or AFGSC/SGP for members in their command) for disposition.

6.47.6.1.3. For all SMOD medication use, all clinical practice and standard of care guidelines must be adhered to, and appropriately documented, before during and after prescribing such medication to SMOD personnel (example: monitoring liver function tests for personnel prescribed some statins, etc.).

6.47.6.1.4. SMOD personnel in non-CMR/BMR 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.

6.47.6.2. OTC medications and Supplements:

6.47.6.2.1. FDA-approved OTC medications and commercially available (in the United States) substances, to include herbal and nutritional supplements, may

generally be used by SMOD 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.

6.47.6.2.2. SMOD personnel are required to consult with the Flight Surgeon whenever:

6.47.6.2.2.1. The member is within 12 hours of reporting SMOD duties and will be using the product for the very first time; or

6.47.6.2.2.2. The member has questions about a product's use or potential side effects; or

6.47.6.2.2.3. The member experiences adverse reactions which may affect the member's ability to perform duties.

6.47.7. **General.**

6.47.7.1. Any medical condition, the natural history of which is to incapacitate an individual suddenly and without warning.

6.47.7.2. Exacerbation of any medical condition for which a waiver has been granted.

6.47.7.3. Blood donation (including plasma and platelet donation): 4 hr restriction from SMOD duty (formal flight surgeon restriction not required).

6.47.8. **Continuation of Space and Missile Operations Duty.**

6.47.8.1. Only a Flight Surgeon may make determinations or recommendations concerning a SMOD crewmember's ability to perform or not perform combat or basic mission ready crew duties.

6.47.8.1.1. When a crew member receives care by a non-flight surgeon provider, the member must be seen immediately by a flight surgeon for appropriate aeromedical disposition. If a flight surgeon is not immediately available, the member must be temporarily removed from space and missile duties until seen by a flight surgeon or the visit is reviewed by a flight surgeon.

6.47.8.2. AF Form 1042 actions (additional guidance on disposition of the AF Form 1042 can be found in **Section 6C**).

6.47.8.2.1. Initial certification: Certified physical and copy of qualifying AF Form 1042 in Part 3 of medical record.

6.47.8.2.1.1. Training: All 13SX and 1C6XX must have qualifying SMOD physical examination certified, as appropriate, by AETC/SG, AFSPC/SGPA, Local Waiver Authority, or appropriate ARC/SG.

6.47.8.2.2. Initial base clearance. Upon reporting to a new base, for duty or training, a complete medical records review and informal examination (using SF 600) will be conducted by a flight surgeon to ensure the member is medically qualified to perform SMOD (additional guidance on disposition of the AF Form 1042 can be found in **Section 6C**).

6.47.8.2.3. Waivers: Copy of certified waiver in Part 3 of medical record and copies of AF Form 1042 to unit commander and in Part 3 of medical record.

6.47.8.2.4. Routine Medical Care or Services.

6.47.8.2.4.1. Active/Operational SMOD (13SX or 1C6XX performing Basic or CMR, or any individual of another AFSC assigned to operational crew duty maintaining mission ready or equivalent status): DNIA/DNIC for any disqualifying medical conditions, medication use or treatments, short or long term, for the period of time that the condition or treatment will last. Copy of DNIA/DNIC AF Form 1042 to individuals' commander and copy in Part 3 of medical record. When condition is resolved or treatment completed Return to Controlling Duties AF Form 1042 to individual's commander and copy in Part 3 of medical record.

6.47.8.2.4.2. Inactive/Non-operational 13SX and 1C6XX. Do not DNIA/DNIC for temporary medical conditions or medication treatment. No AF Form 1042 action required. For long term or potentially disqualifying medical conditions or medication treatments, DNIA/DNIC is required. Copy of AF Form 1042 to individual's commander and copy in Part 3 of medical record. If condition or treatment is long term and/or disqualifying, begin waiver process.

6.47.8.3. PHA is covered in AFI 44-170 and **Section 6C**.

6.47.8.4. AFSPC is the lead MAJCOM for the Cyberspace mission and has designated the AFSCs 1B4 and 17DXA, as well as several 17DXB crew positions require Combat Mission Ready status. These AFSCs and positions must now meet Space and Missile Operations Duty medical standards and have their duty and qualification status managed by AF Form 1042. For implementation instructions, refer to the AFMS KX at: **https://kx.afms.mil/kxweb/dotmil/kjPage.do?functionalArea=AerospaceMedicine&cid=CTB_122236**.

6.47.9. **Additional Testing.**

6.47.9.1. HIV antibody testing is required for all applicants for initial duty. Record the results of cholesterol, HDL, and triglycerides in item 19F or item 42, SF 88, or in appropriate block in DD Form 2808.

6.47.9.2. An Adaptability Rating for Space and Missile Operations Duty (AR-SMOD) and a reading aloud test (RAT) are required on all applicants for initial duty. Record the results in item 41, SF 88 or item 72a in DD Form 2808. The RAT and instructions are contained in AFJI 36-2018 and Physical Examination Techniques located at **https://kx.afms.mil/kxweb/dotmil/kjPage.do?functionalArea=AerospaceMedicine&cid=CTB_124946**

6.47.892. An Adaptability Rating for Space and Missile Operations Duty (AR-SMOD) and a reading aloud test (RAT) is required on all applicans for initial duty. Record the results in item 41, SF 88 or item 72a in DD Form 2808. The RAT and instructions are contained in AFJI 36-2018 and physical examination techniques.

6.47.10. **Pregnancy.**

6.47.10.1. Pregnancy is not necessarily disqualifying for space and missile duties. It may be appropriate to remove an individual from crew duties if she is experiencing some side effects from her pregnancy (e.g. hyperemesis, preeclampsia). The following guidelines must be used for routine pregnancy.

6.47.9.10.1. Missileers - remove from alert duty after 24 weeks gestation.

6.47.9.10.2. Spacelift Operators and Space Warning Operators - remove from shift duty after 32 weeks gestation.

6.47.9.10.3. Satellite Command and Control and Space Surveillance Operators - remove from shift duty after 36 weeks gestation.

Section 6K— Miscellaneous Categories

6.48. Applicability. All personnel who require medical certification to attend the AF survival, evasion, resistance and escape (SERE) course or training courses in our sister services (such as military free fall, free fall jump master, special forces combat diver, dive supervisor, dive medical technician courses) will also need to have their most current physical certified by AETC/SGPS prior to attending training.

6.48.1. **Attendance at Service Schools.** Applicants for all types of training courses must be free of any abnormal physical or mental condition, which is likely to interfere with successful completion of the course. Certain technical training courses and AF specialty classifications impose additional requirements. All personnel must meet flying class III standards as well as any additional Sister Service training requirements (which may be more restrictive).

6.48.2. **Parachute Duty.** The medical standards for all applicants for any type of parachute training and subsequent duty require an Air Force Flying Class III, and any additional requirements as listed below. Refer to US Army Regulation (AR) AR 40-501, *Standards of Medical Fitness* for most current requirements for attendance at Army schools. See N*avy Physical Examination and Standards Article 15-102* for attendance at Navy Dive School.

6.48.2.1. Static Line training only. These individuals must meet initial selection criteria for Airborne training as listed in AR 40-501 or Navy Physical Examination and Standards Article 15-102. Certification authority may be delegated to base level SGPs per MAJCOM waiver delegation policy. Otherwise, certification and waiver authority resides at AETC/SGPS. **Note**: Personnel selected for an incentive jump, must be cleared by a flight surgeon IAW **6.48.8** with a special emphasis on egress capabilities and musculoskeletal system.

6.48.2.2. Military Free Fall, High Altitude-Low Opening (HALO), Jump Master, Pararescue (PJ), Combat Control Team (CCT), CRO, Special Tactics Officer (STO) Duties. These individuals must meet initial selection for Free Fall parachute training as listed in AR 40-501 or Navy Physical Examination and Standards Article 15-102. In addition, SERE, PJ, CCT, CRO, STO must meet Air Force requirements listed in 6.48.3. which must be documented on the DD Form 2808 or SF 88. Initial certification and waiver authority is retained by AETC/SGPS.

6.48.2.3. For personnel scheduled to attend sister service schools, uncorrected visual acuity no worse than 20/200 uncorrected in one eye and 20/70 uncorrected in the better

eye, correctable to 20/20 OU or, those personnel whose uncorrected visual acuity is 20/100 OU, corrected to 20/20 OU. However, all must meet at a minimum the FC III visual acuity requirements as documented in 6.44.7. Note: Sister service school requirements may be more stringent than those for initial Air Force FCIII, but all applicants must meet the sister service standards/requirements.

6.48.3. **Medical Certification and Waiver Requirements for Combat Control (1C2X1) and Pararescue (**1T2X1) Duty and Control and Recovery (13DX) and SERE Specialist (1T0X1). The medical standards for combat control, pararescue, and SERE include the following in addition to 6.48.2. Note: Section 6.4.4. may also apply.

6.48.3.1. Initial Flying Class III examinations for these applicants must include the requirements below in order to meet Army and Navy requirements. The following additional tests must be documented on the SF 88 or DD Form 2808. **Note**: HQ AETC/SGPS retains sole certification and waiver authority.

6.48.3.1.1. Item No 30 - Digital rectal and prostate examination, stool for occult blood.

6.48.3.1.2. Item No 39 - Neurological evaluation by the flight surgeon; each specific item must be addressed (i.e., serial 7's-normal; deltoid 5/5).

6.48.3.1.3. Item No 43 - must read "Type II/Class 1 qualified." Include bite-wing x-rays with package.

6.48.3.1.4. Item No 52 - Chest x-ray (inspiratory and expiratory).

6.48.3.1.5. Item No 52 – Rapid Plasma Reagin (RPR).

6.48.3.1.6. Item No 52 - ECG tracing must be reviewed/signed by a physician.

6.48.3.1.7. Item 52- Must include Complete Blood Count (CBC) results.

6.48.3.1.8. Item No 72 - Reading aloud test (RAT), adaptability rating-diving duty (AR-Diving Duty), ARMA.

6.48.3.1.9. Item No. 73 - Must state: "applicant possesses no fear of heights, depths, dark, or confined places. Applicant possesses the ability to hold breath for 60 seconds subsequent to deep breathing."

6.48.3.1.10. Item No. 81-84. - Must contain all signatures.

6.48.3.1.11. Item No. 78 – Must state: "(is) qualified for initial Flying Class III/Airborne/Combat Control/Pararescue/Marine Diving Duty/SERE Specialist."

6.48.4. **Marine Diving Duty (Pararescue and Combat Control Duty).** The medical standards are those for Flying Class III plus those here and those listed in **6.48.3** Failure to meet standards is cause to reject an examinee for initial Marine Diving duty and for continued duty unless a waiver is granted. Acute medical problems, injuries, or their appropriate therapy may be cause for withholding certification for initial training or temporarily restricting from duty until the problem is resolved.

6.48.4.1. The following conditions are disqualifying:

6.48.4.1.1. Any disease or condition that causes chronic or recurrent disability, sudden incapacitation, or has the potential of being exacerbated by the hyperbaric environment.

6.48.4.1.2. History of injury or procedure involving entrance into thoracic, pericardial, or abdominal cavities in the previous 6 months, or the cranial cavity at any time.

6.48.4.2. Defective Depth Perception.

6.48.4.3. Ear, Nose, and Throat.

6.48.4.3.1. Any history of inner ear pathology.

6.48.4.3.2. Any history of inner or middle ear surgery except PE tubes before age 10.

6.48.4.3.3. Inability to equalize middle ear pressure.

6.48.4.4. Pulmonary. **Note:** Inspiratory and expiratory Chest X-ray is accomplished within 1 year of entering training.

6.48.4.4.1. Congenital and acquired defects which may restrict pulmonary function, cause air-trapping, or affect the ventilation-perfusion balance.

6.48.4.4.2. Chronic obstructive or restrictive pulmonary disease of any type.

6.48.4.4.3. Pneumothorax (512).

6.48.4.5. Gastrointestinal. History of irritable bowel syndrome.

6.48.4.6. Skin and Cellular Tissues. Acute or chronic diseases that are exacerbated by the hyperbaric or marine environment.

6.48.4.7. Dental. **Note:** Dentist signs the SF 88/DD Form 2808 for initial Pararescue or Combat Control duty.

6.48.4.7.1. All divers or hyperbaric chamber operators/personnel (see **6.48.5** for ASC 9C) will be Dental Class I or II before assuming diving duty. Divers who are Dental Class III for acute conditions will be temporarily disqualified from diving duty until the acute condition is corrected. Divers who are Dental Class III because of a chronic condition (e.g. periodontal disease) receive ongoing dental care for the condition if they are to be considered qualified for diving duty. Divers are restricted from diving duty for 48 hours following operative dental procedures.

6.48.4.7.2. Acute infectious diseases of the soft tissues of the oral cavity, until treatment is completed.

6.48.4.7.3. Any defect of the oral cavity or associated structures which interfere with effective use of self contained underwater breathing apparatus (SCUBA).

6.48.4.7.4. Dental corrections are corrected and documented in item #44 of the SF 88/DD 2808 prior to entry into initial Pararescue or Combat Control training.

6.48.4.8. Blood and Blood-Forming Tissues. Any significant anemia or hemolytic disease.

6.48.4.9. Neurologic. Unexplained or recurrent syncope.

6.48.4.10. Psychiatric.

6.48.4.10.1. Personality disorders, neurosis, immaturity, instability, asocial traits, or psychosis.

6.48.4.10.2. Stammering or stuttering.

6.48.4.10.3. Substance use disorder except those who have successfully completed a recognized treatment and aftercare program (see **6.44.24.1.5.1** for demonstrated recovery definition and post treatment aftercare program requirements). Any relapse is cause for disqualification.

6.48.4.10.4. History of claustrophobia.

6.48.4.11. Musculoskeletal. Intervertebral disc disease with neurological deficit.

6.48.4.12. Systemic/Miscellaneous. Any episode of DCS/AGE which produces residual symptoms after completion of all indicated treatment, or persists longer than two weeks. See aircrew waiver guide for further guidance.

6.48.5. **Physiological Training and Physiological Training Personnel (9W)/Hyperbaric Chamber Training/Duty/Operational Support Flying Duty (ASC 9C).**

6.48.5.1. The conditions listed in Chapter 5 and this section are disqualifying for physiological training, hyperbaric duty, and operational support flying personnel.

6.48.5.2. Clearance to complete physiologic training:

6.48.5.2.1. Military personnel on flying status must have a current Flying Class I, IA, II, or III physical on record (or PHA if applicable).

6.48.5.2.2. Military personnel requiring passenger training, who perform aviation duties in ASC 9W and physiological training personnel 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. Examination is required in conjunction with each PHA in accordance with AFI 44-170. Physiologic training personnel do not require a FCIII physical unless on active ASC 9C status. **Note**: AF Form 1042 is issued as satisfactory evidence of completion of the requirements outlined for training and duty.

6.48.5.2.3. AF, Army, or Navy ROTC cadets will present evidence of satisfactory completion of SF 88/DD Form 2808, or DD Form 2351, DOD Medical Examination Review Board (DODMERB) Report of Medical Examination, accomplished within 36 months of the scheduled physiological training. Note: Before scheduling cadets for training, the ROTC detachment must send copies of the SF 88/DD Form 2808, and SF 93/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, is not required for this group of trainees, but any current medical problems must be cleared by the local flight surgeon.

6.48.5.3. Civilians undergoing physiological training are required to present a current FAA medical certificate, or the forms listed in paragraph 6.48.5.2.3. or a valid AF Form 1042.

6.48.5.4. The following conditions are disqualifying for physiological training, hyperbaric duty or operational support flying:

6.48.5.4.1. Any disease or condition that causes chronic or recurrent disability, sudden incapacitation or has the potential of being exacerbated by the hyperbaric/hypobaric environment.

6.48.5.4.2. History of injury or procedure involving entrance in to thoracic, pericardial or abdominal cavities in the previous 6 months, or the cranial cavity at any time.

6.48.5.4.3. Ear, Nose and Throat.

6.48.5.4.3.1. Any history of inner ear pathology.

6.48.5.4.3.2. Any history of inner or middle ear surgery except PE tubes before age 10.

6.48.5.4.3.3. Inability to equalize middle ear pressure.

6.48.5.4.3.4. Current or chronic obstructive ear, nose, throat, sinus.

6.48.5.4.4. Pulmonary.

6.48.5.4.4.1. Abnormal inspiratory or expiratory chest x-ray.

6.48.5.4.4.2. Chronic obstructive or restrictive pulmonary disease of any type.

6.48.5.4.4.3. History of spontaneous pneumothorax.

6.48.5.4.5. Dental-Class III.

6.48.5.4.6. Anemia, significant chronic or nonreversible.

6.48.5.4.7. Gastrointestinal - tendency to excessive flatulence.

6.48.5.4.8. Neurological - unexplained or recurrent syncope.

6.48.5.4.9. Neurosis, or psychosis.

6.48.5.4.10. History of claustrophobia.

6.48.5.4.11. Loss of 200 cc or more blood is disqualifying for at least 72 hours following the loss.

6.48.5.4.12. Sickle cell disease or heterozygous sickling disorders other than sickle cell trait.

6.48.5.4.13. Sickle cell trait if there is a history of symptoms associated with sickling disorder. Symptomology attributable to intravascular sickling during decompression in an altitude chamber is also disqualifying.

6.48.5.4.14. Migraine or incapacitating headaches organic heart disease, or symptomatic hiatal hernia.

6.48.5.4.15. Inguinal hernia.

6.48.5.4.16. Pregnancy.

6.48.5.4.17. Use of medications which may impair mission performance.

6.48.5.4.18. Any disease, which in the judgment of the flight surgeon, is likely to limit the performance of duty or place the individual at increased health risk.

6.48.6. **SERE Specialist Training-Selection and Retention.** The SERE Specialist Training course is physically and mentally demanding and requires the ability to withstand daily running up to 5 miles, 50 pushups, mountain climbing, heat and cold exposure, hiking and backpacking with a weight up to 70 pounds. A medical examination recorded on SF 88/DD Form 2808 and SF 93/DD Form 2807-1 specifically for SERE Specialist duty is required at the time of application. The MMPI, MCMI, and Shipley-Hartford Institute of Living Scale psychological tests are required as part of the application examination. Must complete an IFCIII (Static Line) physical as well as the following:

6.48.6.1. Initial Selection. The causes for rejection are:

6.48.6.1.1. Any condition listed in **Chapter 5.**

6.48.6.1.2. Profile less than P-1, U-1, L-1, H-2, E-2, S-1, except the uncorrected distant vision is not worse than 20/400 each eye corrected to 20/20.

6.48.6.1.3. Speech impediment which interferes with clear enunciation. At a minimum, a Reading Aloud Test (RAT) is required.

6.48.6.1.4. History of recurrent or chronic back pain.

6.48.6.1.5. Scoliosis over 25 degrees measured by the Cobb method. Any other abnormal curvature of the spine of any degree in which there is a noticeable deformity, or in which there is pain, or interference with function, or which is progressive.

6.48.6.1.6. Spondylolysis or spondylolisthesis, if symptomatic.

6.48.6.1.7. History of recurrent knee pain or chondromalacia of the patella. A history of knee surgery requires an orthopedic evaluation and a demonstrated ability of at least 1 year of strenuous physical activity not requiring a brace.

6.48.6.1.8. History of recurrent shin splints.

6.48.6.1.9. History of recurrent ankle sprains.

6.48.6.1.10. History of recurrent foot pain.

6.48.6.1.11. History of stress fractures.

6.48.6.1.12. History of any vertebral fractures, except that history of a healed, asymptomatic fracture of the transverse process is not disqualifying.

6.48.6.1.13. History of surgery involving a major joint requires an orthopedic evaluation.

6.48.6.1.14. History of frostbite or heat exhaustion.

6.48.6.1.15. History of asthma, reactive airway disease or exercise induced breathing difficulties.

6.48.6.1.16. Allergy to stinging insects, pollen, trees, grasses, or dust unless desensitized and controlled on maintenance dosage.

6.48.6.1.17. Deficient night or color vision.

6.48.6.1.18. Food aversions, insect or snake phobias.

6.48.6.1.19. History of personality or behavior disorders.

6.48.6.1.20. History of substance use disorder.

6.48.6.1.21. History of suicidal gesture or attempt.

6.48.6.1.22. Intolerance to close or confined spaces.

6.48.6.1.23. Mental health condition that indicates the applicant is unable to accept constructive criticism or unable to function in a high stress environment.

6.48.6.2. Retention. A trained and experienced survival instructor is considered using these standards as a guide, but continued duty is dependent upon the member's demonstrated ability and performance.

6.48.6.3. Certification and Waiver Authority. AETC/SGPS is the medical certification and waiver authority for selection and retention of SERE Specialists and trainees.

6.48.7. **Duty Requiring Use of Night Vision Devices (NVD).**

6.48.7.1. Aircrew members and special operational duty personnel who wear NVDs in the performance of their duties are required to achieve at least 20/50 visual acuity with the NVDs in the pre-flight test lane. Aircrew who fail visual acuity standards for their flying class, complain of visual problems either with or without NVDs, or fail to achieve 20/50 visual acuity in the NVD pre-flight test lane must be referred for a clinical eye examination. The flight surgeon must refer to AL-SR-1992-0002, *Night Vision Manual for Flight Surgeon*s, for additional guidance.

6.48.7.1.1. Personnel required to inspect, maintain or certify NVDs 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 of which will be documented in their medical records and re-certified annually as long as their duties include NVD inspection, maintenance or certification. Technicians with visual acuity less than 20/20 may be issued spectacles IAW **6.48.7.2** to correct their vision. Technicians who can not attain visual acuity of 20/20 corrected or uncorrected in each eye will be restricted from performing NVD inspection, maintenance or certification.

6.48.7.2. Each aircrew or special operational duty member who requires corrective lenses in order to meet the visual acuity standards for flying, and who is required to wear NVGs in the performance of flying duties, must 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:

6.48.7.2.1. If the individual has not had a refraction done within the past year, obtain a current refraction.

6.48.7.2.2. Send the current prescription written on a DD Form 771, *Eyewear Prescription*, with verification of NVG duties written in the "Special Lenses or Frame" block to: Optical Fabrication Research Unit, USAFSAM/FECO, 2507 Kennedy Circle, Brooks City-Base TX 78235-5116.

6.48.7.2.3. Dispense the glasses to the individual with instructions to wear them only when using NVG and to protect the lenses from marring or scratching.

6.48.8. **Incentive and Orientation Flights.**

6.48.8.1. Incentive and Orientation Flights in Ejection Seat Aircraft.

6.48.8.1.1. 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. A flight surgeon will accomplish a medical records review and a physical examination (scope of examination to be determined locally). 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. Communicate medical clearance and recommendations and/or restrictions to the flying unit on AF Form 1042. 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:

6.48.8.1.2. Signed parental consent is required if candidate is not on active duty and under the age of 18.

6.48.8.1.3. Body weight, buttock-to-knee and sitting height measurements must be within minimums and maximums as specified in table below:

Table 6.4. 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	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

6.48.8.1.4. Individuals selected for incentive or orientation flights who do not meet anthropometric standards will be referred to the flying unit or wing commander (06 or above) for final authority disposition. 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.

6.48.8.2. Incentive and Orientation Flights in Non-Ejection Seat Aircraft.

6.48.8.2.1. 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. Candidates must be able to safely egress the aircraft in an emergency without endangering life or limb. 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. Passengers scheduled to fly onboard Air Force aircraft will not routinely be referred to the flight surgeon office. Communicate medical clearance, recommendations and/or restrictions to the flying unit on AF Form 1042. Medical clearances for incentive and orientation flights are valid for no longer than 14 days with the exception of AMP 101 candidates. See the AMP 101 website for further information. Note: ARC clearances will be valid for no longer than 40 days.

6.48.9. **Instructors and students participating in United States Air Force Academy (USAFA) Airmanship programs.** The medical standards for these duties are the same as **Section 6G/6K** (except as noted below):

6.48.9.1. Flying Class III standards apply to Dean of Faculty (DF) parachute courses. RPA standards apply to all DF RPA programs. Flying Class II standards apply to all soaring/powered flight courses. The following exceptions apply:

6.48.9.1.1. Refractive error, no standards.

6.48.9.1.2. Applicants for programs in **6.48.9.1** 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.

6.48.9.1.3. Color Vision, no Standard.

6.48.9.1.4. Depth perception:

6.48.9.1.4.1. No standard for DF flight, parachute, RPA, and student soaring programs provided the soaring instructor pilot has normal depth perception.

6.48.9.1.4.2. Participants with abnormal depth perception are disqualified from solo flight.

6.48.9.2. For USAFA flying and parachute programs, FAA 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, *Medical Recommendation for Flying or Special Operational Duty* will be generated prior to performing flying operations in USAFA owned aircraft.

6.48.9.3. 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:

6.48.9.3.1. Compliance with **6.48.9.1** Accomplished by review of all available medical documentation and appropriate physical examination to ensure standards are met. This will be coordinated with Force Health Management.

6.48.9.3.2. 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.

6.48.9.3.3. 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.

6.48.9.3.4. Cadets receive physiology training prior to flight or at least prior to solo flight.

6.48.9.3.5. 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 6.48.9.3.3. 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.

6.48.9.3.6. Grounding management of all cadet participants will convey temporary disqualification and clearances following illness or injury to the local HARM. For grounding management purposes, civilians will comply with all FAA regulations and guidance.

6.48.9.3.7. The USAFA airmanship program medical clearance expires upon graduation. While matriculating at 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.

6.48.9.3.8. 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, FCIIU, SMOD, GBC standards. AETC/SG is the approval and waiver authority for Initial Flying Class I, IA, II, or III physical examinations.

6.48.9.3.8.1. HQ AETC/SG certified Flying Class I physical examination must be completed prior to entering SUPT after graduation from USAFA.

6.48.9.4. The USAFA/SGP is the approval and waiver authority for USAFA Airmanship Programs and courses covered under this attachment.

6.48.10. **Interservice Transfers.**

6.48.10.1. Pilots of fighter aircraft transferring from sister service to Air Force fighter aircraft are considered trained assets. FCII AF standards apply. Pilots must be tested for and meet color vision and depth perception per AF standards. Complete all requirements for pilot's age IAW with PHA and PIMR guidelines. This FCII physical will be entered into PEPP for baseline comparison and into AIMWTS if flying waiver required. Pilots of fighter transferring to AF non-fighter aircraft are not considered trained assets. 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.

6.48.10.2. Pilots of rotary wing aircraft transferring from sister service to Air Force rotary wing aircraft are considered trained assets. FCII AF standards apply. Pilots must be tested for and meet color vision and depth perception per AF standards. Complete all requirements for pilot's age IAW with PHA and PIMR guidelines. This FCII physical will be entered into PEPP for baseline comparison and into AIMWTS if flying waiver required. Pilots of rotary wing aircraft transferring to AF non-rotary wing aircraft are not considered trained assets. 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.

6.48.10.3. Pilots of fixed wing (non-fighter) aircraft transferring from sister service to Air Force (non-fighter) fixed wing aircraft are considered trained assets. FCII AF standards apply. Pilots must be tested for and meet color vision and depth perception per AF standards. Complete all requirements for pilot's age IAW with PHA and PIMR guidelines. This FCII physical will be entered into PEPP for baseline comparison and into AIMWTS if flying waiver required. Pilots of fixed wing aircraft transferring to AF fighter or rotary wing aircraft are not considered trained assets. 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.

6.48.11. Small (smaller than Predator Class) Unmanned Aircraft Systems Operators (SUAS-O) and RPA visual observers.

6.48.11.1. Must meet standards as outlined in **Chapter 5**, Continued Military Service (Retention) and the following:

6.48.11.1.1. Distant Visual Acuity and Near Visual Acuity corrected to 20/20 OU or better.

6.48.11.1.2. Color vision as demonstrated by the Pseudoisochromatic Plates (PIP 1) as outlined in **6.44.10**

6.48.11.1.3. No medical condition present which may incapacitate an individual suddenly or without warning.

6.48.11.1.4. Personnel may not perform SUAS-O duty while using any medication whose known common adverse effect or intended action(s) affect alertness, judgment, cognition, special sensory function or coordination. This includes both over the counter and prescription medications. SUAS-O personnel requiring use of the above medications should be restricted from operating SUAS, documented on AF Form 469. Consider removal from SUAS-O duties for ground trial of any medications that have potential to cause idiosyncratic reactions.

6.48.11.1.5. Document qualification on AF Form 422. Do not use PEPP or Air Force Form 1042 for processing or selection. SUAS-Os do not require flight Surgeon oversight. Duty restrictions for these members will be managed on AF Form 469.

6.49. (Added-AFMC) Maintenance Engineering Support Personnel (MESP). Physicians should review and be familiar with AFI 11-202V3, *General Flight Rules*, para 6.4 and 6.5, AFI 11-403, *Aerospace Physiological Training Program*, para 2.1 thru 2.3 and the AFI 11-409, *High Altitude Airdrop Mission Support Program, A2.2*

6.49.1. **(Added-AFMC) General Medical Criteria**. Military and government civilian personnel performing MESP duties, who do not require physiological training and subject to cabin altitude limits listed in AFI 11-202V3 para 6.4.1.4 (certain unpressurized operations), must not have any of the disqualifying conditions listed in AFI 48-123, chapter 6.48.5. *Physiologic Training and Physiologic Training Personnel (9W)/Hyperbaric Chamber Training/Duty/Operational Support Flying Duty (ASC 9C)*, or the conditions listed below (see para 6.49.5.4. for contractors):

6.49.1.1. **(Added-AFMC)** Symptomatic coronary artery disease such as angina pectoris, heart failure, heart replacement, permanent cardiac pacemaker or other functionally significant cardiac disease

6.49.1.2. **(Added-AFMC)** Elevated blood pressure greater than systolic of 160 mm/Hg and/or diastolic over 100 mm/Hg. If elevated at time of medical examination, perform a 3 day blood pressure check.

6.49.1.3. **(Added-AFMC)** Vertigo within 1 year or recurrent vertigo.

6.49.2. **(Added-AFMC) Medical Criteria for Special Situations**. Military and government civilian personnel performing MESP duties, who require physiologic training IAW AFI 11-403 and paragraph 6.49.4 below; or subject to cabin altitude limits listed in AFI 11-202V3 paragraph 6.4.1.4 (certain unpressurized operations), will meet the requirements listed above and must also not have any of the disqualifying conditions listed in AFI 48-123, Chapter 6.44 or those below (see para 6.49.5.4. for contractors):

6.49.2.1. **(Added-AFMC)** 6.44.16., Lungs and Chest Wall (exception: may have stable breast implants).

6.49.2.2. **(Added-AFMC)** 6.44.17., Cardiovascular System (exception: can have blood pressure under control with appropriate medication).

6.49.2.3. **(Added-AFMC)** 6.44.23., Neurological Disorders

6.49.3. **(Added-AFMC) Standing Height, Sitting Height and Weight**. All MESP personnel who fly in ejection seat aircraft must also meet the following AF anthropometric standards.

6.49.3.1. **(Added-AFMC)** Standing height no less than 64 inches and no greater than 77 inches.

6.49.3.2. **(Added-AFMC)** Sitting height no less than 33 inches and no greater than 40 inches.

6.49.3.3. **(Added-AFMC)** Weight no less than 103 pounds or greater than 240 pounds for T-38 and 245 pounds for all other ejection seat aircraft.

6.49.4. **(Added-AFMC) Physiological Training**. All MESP who fly in aircraft flying above 18000 feet MSL require physiological training IAW AFI 11-403, *Aerospace Physiological Training Program*; MESP qualify as passenger exceptions when flying in E-3, E-4, E-8, KC-10, C/KC/ RC/EC-135, EC-130, EC-137, MC-130, AC-130, WC-130, T-1, T-39, T-43, and C-designated aircraft. Only essential personnel who have accomplished appropriate physiological training described in AFI 11-403 are permitted on mission aircraft for airdrops above 10,000 feet MSL.

6.49.5. **(Added-AFMC) Physical Examination Procedures and Annotations of Medical Status.**

6.49.5.1. **(Added-AFMC)** Military personnel require a flight surgeon review of available medical records, a current PHA, or an AF physical exam to determine if the member meets the medical requirements listed above. This clearance will be documented on an AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty* IAW paragraph 6.49.5.3.1 or 6.49.5.3.2 and will be good for up to 15 months (455 days) from the date of the review (unless covered by deployment criteria in AFI44-170 AFGM1 dated 2 Nov 2011). During the period of medical clearance, MESP candidates must report any change in medical status to the flight surgeon prior to engaging in in-flight activities. Waiver authority for MESP is the installation SGP.

6.49.5.2. **(Added-AFMC)** US Government civilians performing MESP will be evaluated with the criteria listed in para 6.49.1 and 6.49.2 according to their mission to ensure there is no undue medical risk to the individual, aircrew, safety or mission completion. The MTF flight surgeon will annotate medical records regarding this evaluation. The examination will be valid for up to 15 months (455 days) from the date accomplished. It will be documented IAW paragraph 6.49.5.3. During the period of medical clearance, MESP candidates must report any change in medical status to the flight surgeon prior to engaging in in-flight activities. Waiver authority for MESP is the installation SGP.

6.49.5.3. **(Added-AFMC)** Military and US Government civilian personnel will receive an AF Form 1042, signed by an AF credentialed flight surgeon as satisfactory evidence of medical qualification for duties.

6.49.5.3.1. **(Added-AFMC)** If the training requirements of AFI 11-403 have not been met, the SGP should annotate on the AF form 1042: "RESTRICTED TO FLIGHT ALTITUDES LESS THAN 18,000 FEET MSL OR 10,000 FEET MSL (UNPRESSURIZED); FLIGHT LEVELS NOT RESTRICTED FOR NORMAL PRESSURIZED DUTIES IN E-3, E-4, E-8, KC-10, C/KC/ RC/EC-135, EC-130, EC-137, MC-130, AC-130, WC-130, T-1, T-39, T-43, and C-designated aircraft".

6.49.5.3.2. **(Added-AFMC)** Individuals who will or may fly in ejection seat aircraft, but are not qualified for some or all ejection seat types IAW AFI 48-123, 6.48.5 will have an additional specific annotation made: " QUALIFIED FOR FLIGHT IN____(list aircraft here)____ONLY" on the AF Form 1042.

6.49.5.4. **(Added-AFMC)** Contractor personnel. Submission of an FAA 3rd Class Airman's Medical certificate is satisfactory evidence of qualification when authorized IAW DCMA 8210.1. It is not the responsibility of the MTF to provide such exams. Such exams will be adequate for the inherent duration of the certificate but will not be considered valid beyond the guidance of DCMA Inst 8210.1. AF Form 1042's will not be issued for contractor personnel. Contractor personnel will maintain a copy of AF Form 702 or AF Form 1274 or other similar documentation to indicate their completion of appropriate physiological training.

Chapter 7

OCCUPATIONAL HEALTH EXAMINATIONS

Section 7A— Occupational Health Examinations

7.1. Purpose. Occupational and Environmental Health Medical Examinations (OEHME) are done to ensure fitness for duty, to protect the working population by assessing adequacy of controls, and to identify work-related illness at a sub clinical state where a useful intervention can be made. The examinations are conducted to assist in maintaining a fit force essential to mission readiness and to assure the Air Force meets its obligation under Title 29, United States Code, Sec 651, Occupational Safety and Health Act of 1970 to provide a safe and healthful workplace. Instruction and guidance for OEHMEs can be found in AFI 48-145, *Occupational and Environmental Health Program*, AFOSH 48-20, AFOSH STD 48-137, *Respiratory Protection Program*, AFMAN 48-155, *Occupational and Environmental Health Exposure Controls*, AFOSH STD 48-8, *Controlling Exposures to Hazardous Materials* and DoDI 6055.05 *Occupational and Environmental Health (OEH).*

7.2. Who Receives These Examinations. The need, type and frequency of exams for both civilian and military workers is determined in the local Occupational and Environmental Health Working Group (OEHWG), subject to the final approval authority of the physician chair.

7.3. Public Health (SGP for the ARC). Performs administrative quality control review/oversight on these examinations to ensure completeness. Reports discrepancies to the Installation Occupational and Environmental Medicine Consultant for review and determination of appropriate action. Where examinations are completed along with PHA, MTF/CC may combine PHA and OH reviews to be accomplished concurrently by one section.

7.4. Results of OEHMEs. Results of OEHMEs are maintained in accordance with AFOSH standards and AFI 48-145 and are one source of input to the multidisciplinary Occupational Health Program.

7.5. Types of Examinations.

7.5.1. Clinical Surveillance Examinations. Detailed guidance for clinical surveillance examinations are found in AFI 48-145 and DoDI 6055.05.

7.5.2. Firefighters. DoDI 6055.6, *DOD Fire and Emergency Services (F&ES) Program*, provides instruction for fitness standards for firefighters. HQ AFCESA/CEFX, in conjunction with HQ AF/SG3PF, develops National Fire Protection Association Technical Implementation Guides (TIGs) for assistance in implementing fitness policy. The TIGs are available on the AFCESA's web site, and **www.kx.afms.mil/occdoc**. Military firefighters with any Category A conditions and Category B conditions (see National Fire Protection Association 1582, *Standard on Comprehensive Occupational Medical Program for Fire Departments)* where there is a clear fitness-for-duty issue, or they no longer meet standards for continued military service IAW **Chapter 5**, must be evaluated with adherence to Medical Evaluation Board procedures.

7.6. Examination Requirements.

7.6.1. Examination requirements are determined in the installation OEHWG. The physician Chair of the OEHWG is the final approval authority for examination requirements. Details on the OEHWG process are found in AFI 48-145.

7.6.2. Useful guidance for examination criteria is found in DoDI 6055.05, AFI 48-145, AFOSH STD 48-137, AFMAN 48-155 and NEHC-TM OM 6260, Medical Surveillance Procedures Manual and Medical Matrix.

7.7. Forms Required.

7.7.1. Standard Form 78, *Certificate of Medical Examination*s (or equivalent): This form is used when the management or the civilian personnel office formally requests an examination under 5 Code of Federal Regulations (CFR), 339, *Medical Qualification Determinations.* This form provides a listing of functional and environmental factors essential to the examination and placement of civilian workers.

7.7.1.1. Management must provide the SF 78, *Certificate of Medical Examination*, or equivalent, and a listing of functional and environmental factors essential to the examination and placement of the civilian worker. The medical provider records findings and conclusions on the SF 78, or equivalent, and returns page 3 of this form to the responsible personnel office. Utilization of DD Form 2766, or equivalent, for additional pre-employment examination criteria will provide for one-stop examination and established baseline occupational studies.

7.7.1.2. A copy of the entire form SF 78, or equivalent, must be kept in the worker's medical record. An appropriate medical history must be obtained and documented as well (e.g. paragraph **7.7.2**).

7.7.1.3. When completing SF 78 Section D "Agency Medical Officer", the examining provider must not make hire/don't hire/separate/retain determinations. Provider must simply describe absence or presence of functional limitations and/or unacceptable environmental factors. If a provider feels a condition is disqualifying based on a particular medical standard, consultation (at least telephonic) with a Board Certified occupational medicine physician must be obtained.

7.7.2. Standard Form 600, *Health Record—Chronological Record of Medical Care or equivalent).* OEHMEs are recorded on SF 600 forms in AHLTA.

7.7.3. Other forms. The AF Form 469, AF Form 422, or equivalent, can also be used for the communication of functional abilities, as well as a CA-17, CA-20 or other appropriate form.

7.8. Consultations. If the healthcare provider suspects an individual's illness is job-related, the practitioner notes pertinent historical and clinical data on SF 513, *Medical Record--Consultation Shee*t, or equivalent, and sends it to Public Health.

Chapter 8

MEDICAL EXAMINATIONS FOR SEPARATION AND RETIREMENT

Section 8A— Overview

8.1. 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).

8.2. Purpose. To identify medical conditions requiring attention and to document current medical status to determine continued fitness for duty.

8.3. 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 active duty or retirement, unless there is clear and convincing evidence to the contrary. (See AFI 41-210 for presumption of fitness prior to retirement)

8.4. Law Governing Disability Evaluation.

8.4.1. Title 10, United States Code, Chapter 61 provides for disability retirement and separation.

8.4.2. 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.

8.4.3. Title 10, United States Code Sec 1145 directs conduct of separation examinations on specific individuals leaving the USAF.

8.5. Mandatory Examinations.

8.5.1. A medical assessment by a credentialed provider and documented on DD Form 2697 and supporting documents as outlined in **8.5.2** is mandatory when:

8.5.1.1. Member has not had a PHA within one year. 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

8.5.1.2. Medical authority requires an examination to be done for either clinical or administrative reasons.

8.5.1.3. 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.

8.5.1.3.1. If the member has had an initial enlistment/commissioning examination within the preceding 12 months, DD Form 2697 will be the only requirement.

8.5.1.4. A medical assessment with provider exam as outlined in paragraph **8.5.2** DD Form 2697, as a minimum, is required for members having had a PHA within one year of

AFPC approved retirement date (no SF 88 or 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. 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 Veteran's Administration Transition Officials if the member is expected to file a disability claim with the VA. The 2697 is only required for AFRC members leaving an active duty tour of 31 days or more and is not required for retirement purposes if the PHA is current.

8.5.1.5. The member is tentatively approved by HQ AFPC for early separation from active duty and assignment into an ARC under PALACE CHASE, 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 Fast Track or an MEB while on AD.

8.5.1.6. The member is tentatively approved by HQ AFPC for early separation from active duty and assignment into the ARC under 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 Fast Track or an MEB while on AD.

8.5.1.7. The member's medical record has been lost. Accomplish Preventive Health Assessment with SF 93 /DD 2807-1 along with the DD Form 2697. Provider examination must address significant medical history and determine if qualification for continued service is questionable.

8.5.1.8. The member is a Repatriated Prisoner of War (Mil-PDS assignment limitation code 5, or 7). The evaluation will include a RILO MEB unless waived by HQ AFPC/DPAMM. Forward a copy of the examination to the addresses in **6.8.5.2**

8.5.1.9. Members of the reserve component separated from active duty to which they were called or ordered in support of a contingency and for whom the period of active duty exceeded 30 days. This includes ARC members called/ordered to initial active duty for training, active duty, or Federal Service during times of contingency, conflict, or war.

8.5.1.10. Members separated from active duty who pursuant to voluntary agreement of the member to remain on active duty for less than one year, unless **8.5.1.3.1** applies.

8.5.1.11. Members involuntarily retained on active duty in support of a contingency unless they have a current (within 12 months preceding the actual date of separation) PHA.

8.5.2. Medical Assessment (DD Form 2697). Members who require a separation examination IAW **8.5.1** will complete, as a minimum, a medical assessment as described below. 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 **8.5.1.4**)

8.5.2.1. The assessment must include:

8.5.2.1.1. A completed DD Form 2697 (see paragraph **1.10**).

8.5.2.1.2. 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. See the last two sentences in Section II, DD Form 2697 for additional guidance.

8.5.2.1.3. 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. 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.

8.5.2.1.4. All personnel 35 years of age and older who are separating or retiring from the Air Force will complete screening for Hepatitis C IAW HA policy 99-00016.

8.5.2.2. File the completed DD Form 2697 in the medical record. If the medical record is not available, forward DD Form 2697 sealed, to the Separation and Retirements Section of the member's servicing MPF. File a copy of the form in the dental record if a dental problem was identified during the assessment. File all consultation reports with the DD Form 2697.

8.5.2.3. 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)/DSFRA for retention as required by Title 10, United States Code, Chapter 8502.

8.5.2.4. 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.

8.5.2.5. HIV testing for separation or retirement is required only when deemed appropriate by the primary care manager (Consult AFI 48-135, *Human Immunodeficiency Virus Program*).

8.5.3. Termination Occupational Examinations. If required, accomplish termination occupational examinations during the separation or retirement examination/assessment (see **Chapter 7** on termination exams).

8.6. General Officers. Examinations for retirement must be conducted IAW AFI 36-3203, Service Retirements, Chapter 5.5.

Chapter 9

MEDICAL CLEARANCE FOR JOINT OPERATIONS OR EXCHANGE TOURS

Section 9A— Medical Clearance for Joint Operations or Exchange Tours

9.1. Applicants. Air Force personnel must meet Air Force standards while in joint assignments, or inter-Service exchange tours.

9.1.1. 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.

9.1.2. 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.

9.1.3. Medical examinations performed by other services are acceptable, but must be reviewed and approved by the appropriate Air Force waiver authority.

9.1.4. 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.

9.2. Joint Training.

9.2.1. 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.

9.2.2. After students in-process at the host base, the administrative requirements and medical management policies of the host base apply.

9.2.3. Students must meet the physical standards of the parent service.

9.2.4. Individuals who develop medical problems while in training must not be continued unless both host and parent services concur.

9.2.5. In cases of irreconcilable conflict, host service decision takes precedence (consult with MAJCOM/SGPA for further guidance).

Chapter 10

NORTH ATLANTIC TREATY ORGANIZATION (NATO) AND OTHER FOREIGN MILITARY PERSONNEL

Section 10A— NATO Personnel

10.1. Implementation. This chapter implements STANAG 3526, Interchangeability of NATO Aircrew Medical Categories.

10.2. Evidence of Clearance. Definitions: The host nation is the nation where Temporary Duty (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.

10.2.1. Local (Host) MTF flight surgeons prepare AF Form 1042 based on the standards of medical fitness for flying duties issued by the parent country.

10.2.1.1. 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.).

10.2.2. 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.

10.2.2.1. 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.

10.2.3. In the case of progression of an 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 **10.2.5**).

10.2.4. 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.

10.2.5. Groundings exceeding 30 days and permanent medical disqualification must be discussed with AFMSA/SG3P and the appropriate parent nation liaison.

10.3. Medical Qualification of NATO Aircrew Members:

10.3.1. NATO Aircrew will have the same medical benefits and requirements as USAF aircrew (See AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health System (MSS).* **Note:** Members must have documentation in the medical record that a DNA sample has been obtained and on record.

10.3.2. Waivers for flying or other special operational duty positions granted by another nation may not necessarily be continued upon return to the USAF.

10.4. Medical Qualification for Security Cooperation Education and Training Program (SCETP) Flying (Non-NATO Students):

10.4.1. 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 (JSCET*).

10.4.2. All medical qualification documentation will be forwarded through SCETP to HQ AETC/SGP NLT 30 days before training or Defense Language Institute (DLI) start date. AETC/SGP will determine if flying student candidate possesses adequate physical examination documentation and is qualified under **Chapter 6, Section 6G**. AETC/SGP will certify student as qualified with or without waiver prior to issuing Invitational Travel Order (ITO) IAW JSCET.

10.4.3. Any student who fails to meet medical standards will be managed on an individual bases by HQ AETC/SG and HQ AETC/IA, who will in turn, coordinate with AF/SG (AFMSA/SG3P), SAF/IA as appropriate.

10.5. 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 11

EXAMINATION AND CERTIFICATION OF ARC MEMBERS NOT ON EAD

Section 11A—Examination and Certification of ARC Members Not on Extended Active Duty (EAD)

11.1. 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 AFMAN 36-8001, *Reserve Personnel Participation and Training Procedures*, any USAFR member profiled "4", duty limiting condition, code 31, 37, 81 (previously "4T") may not perform military duty for pay or points, unless issued a participation waiver by the AFRC/SGP or delegated authority. ANG members may perform military duty for pay and points (UTA only) if so determined by the members commander (IAW AFI 10-203).

11.2. Terms Explained.

11.2.1. ARC Unit and individual members of the ANG and Air Force Reserve, IMA.

11.2.2. ARC Members of the Ready Reserve:

11.2.2.1. Air National Guard. Administered by ANG/SGP.

11.2.2.2. Air Force Reserve Unit Member. Administered by HQ AFRC/SGP (Headquarters Air Force Reserve Command, Aerospace Medicine Division)

11.2.2.3. IMA. Administered by HQ AFRC/SGP.

11.2.2.4. Participating Individual Ready Reserve Members (Category E). Administered by HQ AFRC/SGP.

11.2.3. 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.

11.3. Medical Standards Policy. Each ARC individual must be medically qualified for deployment and continued military service according to **Chapter 5** and **Chapter 13**.

11.4. Responsibilities.

11.4.1. Commander or Supervisor. Each ARC commander or active force supervisor ensures an ARC member is medically qualified for worldwide duty. Each commander and supervisor notifies the servicing medical facility when he/she becomes aware of any changes in an ARC member's medical status.

11.4.2. ARC Member. Each ARC member is responsible for promptly reporting a disease, injury, operative procedure or hospitalization not previously reported to his or her commander, supervisor, or supporting medical facility personnel. 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.

11.4.3. ARC Physicians. Responsible for determining ARC member's medical qualifications for continued worldwide duty IAW this instruction and appropriate ARC supplemental guidance.

11.4.4. Air Force medical service personnel record any injury or disease incurred or contracted by ARC members during any training period on appropriate medical forms since the injury or disease is the basis for a claim against the government, to include initiation of a Line of Duty Determination.

11.5. General Responsibilities/ARC Medical Units.

11.5.1. Establish health and dental records for each ARC member.

11.5.2. 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. HQ AFRC/RMG/SG, 233 North Houston Road, Suite 131-A, Warner Robins, GA 31093. MEB packages shall undergo standard MEB processing through the MTF and IPEB. HQ AFRC/SGP retains authority to assign Assignment Limitation Code C (ALC-C) codes for IMAs returned to duty IAW AFI 41-210, Chapter 10.

11.5.3. 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.

11.5.4. All Air National Guard 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 Air National Guard member qualification for worldwide duty.

11.5.5. Send complete medical case files on ARC members with questionable medical conditions or found medically disqualified. 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.

11.6. 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.

11.6.1. The appropriate ARC/SG must review and certify all applicants identified with **Chapter 5** 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.

11.6.2. The Chief, Aerospace Medicine of the gaining/supporting AFRC medical unit or active duty MTF and ANG State Air Surgeon may certify, but not waiver for entry into active reserve status all applicants not identified in paragraph **11.6.1** above using **Chapter 5** medical standards.

11.6.2.1. **DELETED.**

11.6.3. The following documentation is required for all applicants:

11.6.3.1. Current DD Form 2807-1 (Recruiting Form).

11.6.3.2. Current Reserve Web Health Assessment (Web HA) with supporting documentation for positive responses (AFRC only).

11.6.3.3. PHA with associated paperwork less than 12 months old (non aircrew assignments).

11.6.3.4. Flying PHA with associated paperwork less than 12 months old (aircrew assignment same as previous aircrew AFSC).

11.6.4. Applicants applying for a new aircrew position, rather than the one previously held will require an initial flying exam. Applicants whose RCHRA or PHA is greater than 12 months old will require a current enlistment or flying exam as appropriate.

11.7. 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.

11.8. 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.

11.9. 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.

11.10. Active Guard Reserve (AGR) Tours. The AGR program requires individual applicants to contact the appropriate ARC medical unit, or active duty MTF, to request the appropriate medical evaluation. The following guidance along with AFI 36-2132, *Full-time Support (FTS) Active Guard Reserve* (AGR) *Program* and ANGI 36-101, *The Active Guard/Reserve (AGR) Program*, will be used to manage these requests.

11.10.1. 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 Disability Evaluation System (AFDES) IAW AFI 36-3212, *Physical Evaluation for Retention, Retirement, or Separation.*

11.10.2. Physical Exam Requirements.

11.10.2.1. Applicants with a concurrent AGR assignment must have a current PHA on file.

11.10.2.2. 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**, **Section 6G** (aircrew applicants only).

11.10.2.3. 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** apply. Prior service (IRR, etc.) applicants for non-aircrew assignments within 180 days of separation may use the same standards as active duty. Applicants whose date of separation is greater than 180 days will require an accession examination and medical standards in **Chapter 4** apply.

11.10.2.4. For aircrew assignments into the applicant's current aircrew AFSC, flying PHA with associated paperwork less than 12 months old may be used.

11.10.2.4.1. Applicants for new aircrew assignments require an initial flying examination.

11.10.3. Certification/Waiver Authority.

11.10.3.1. The Chief, Aerospace Medicine of the gaining/supporting ARC medical unit or active duty MTF may certify, but not waive, all applicants for non aircrew AGR positions and aircrew AGR positions in which the applicant currently holds the AFSC as long as no disqualifying medical conditions or medical conditions which require a flying waiver are identified. Medical standards in **Chapter 5** and **Chapter 6**, **Section 6G** apply. For ANG, the State Air Surgeon, having completed specialized training, is authorized certification authority for Title 32 AGR applicants.

11.10.3.1.1. The Chief, Aerospace Medicine/State Air Surgeon (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.

11.10.3.2. The appropriate ARC/SG is the reviewing, certification and waiver authority (see **Attachment 2**) for those applicants with disqualifying medical conditions in **Chapters 4 and 5 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.

11.11. Involuntary EAD. ARC members involuntarily ordered to active duty will not delay such action because of an expired PHA. The PHA will be accomplished prior to deployment or TDY from the recall to active duty location. The PHA must be accomplished within the first 60 days of active duty.

11.11.1. An ARC member ordered to EAD due to mobilization is medially processed IAW the mobilization order. The ARC member's medical status must be established within 30 days of mobilization.

11.11.2. Within 30 days of mobilization, the health records of the ARC member will be reviewed for disqualifying defects according to **Chapter 5** and to determine if the member's PHA is current. Members found medically disqualified or questionably qualified for worldwide duty are evaluated IAW AFI 41-210, unless otherwise directed by the mobilization order. Members determined to have expired PHA, will have a PHA accomplished within 60 days of mobilization.

11.12. Annual Training (AT) or Active Duty for Training or Inactive Duty for Training (IDT). Commanders ensure members reporting for duty are medically qualified under current directives. Members with medical conditions, which render questionable their medical qualifications for continued worldwide duty, are evaluated for fitness for duty.

11.13. Inactive Duty for Training.

11.13.1. ARC members who are ill, sustain an injury, or do not consider themselves medically qualified for military duty can request excusal from training.

11.13.2. 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 active duty supervisor will schedule the member for a medical evaluation during the IDT period. If the member is not qualified for worldwide duty, a medical evaluation is sent to AFRC/SGP, or NGB/SGPA as appropriate. The member is excused from training pending a review of the case. **Note**: ANG members will be given a DLC (AF Form 469) and follow the guidance found in AFI 10-203.

11.13.3. When a commander, supervisor, or medical personnel determines an ARC member's medical condition is unfit, he or she is evaluated by the servicing medical squadron and is excused from all military duties pending further medical disposition.

11.14. Medical Examination.

11.14.1. General Information:

11.14.1.1. Medical personnel perform medical examinations according to **Chapter 1** and physical examination techniques.

11.14.1.2. 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.

11.14.1.3. All Air National Guard members must complete their PHA annually.

11.14.1.4. ANG MPF and commander are notified by the ANG Medical Group when a member cannot continue the UTA because of a medical condition. AF Form 469 is utilized for notification, as appropriate.

11.14.2. Dental Class III.

11.14.2.1. AFRC members placed in dental class III are not qualified military duty other than at home station until returned to Dental Class 1 or 2. Manage AFRC members IAW paragraph **11.16** 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 will be processed for MEB/WWDE. More Guidance in AFI 47-101, *Managing Air Force Dental Services*.

11.14.2.2. 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.

11.14.2.2.1. 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. Aircrew in this status will be limited to local sorties only.

11.15. Scheduling PHA. Schedule a PHA in accordance with current ARC directives PIMR/PHA Guide.

11.16. Medical Evaluations to Determine Fitness for Duty.

11.16.1. Reasons to accomplish medical evaluations in determination of medical and dental qualification for military duty:

11.16.1.1. Disqualifying or questionable medical conditions discovered during the annual assessment.

11.16.1.2. Notification or awareness of a change in the member's medical status.

11.16.1.3. ARC member believes he or she is medically disqualified for military duty.

11.16.2. 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. 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. 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.

11.16.3. Notification. The commander or supervisor notifies the ARC member, in writing, to report for the medical evaluation.

11.16.4. Accompanying Documents. The following documents are included in the reports forwarded to the appropriate component surgeon (**see paragraph 11.5**) for review. Unless otherwise specified all reports contain the original and two copies of each document, properly collated and stapled into three separate stacks.

11.16.4.1. For unit assigned or IMA reserve members:

11.16.4.1.1. Civilian medical and dental documentation.

11.16.4.1.2. Current letter from member's private physician or dentist.

11.16.4.1.3. AF Form 469 properly formatted.

11.16.4.1.4. 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.

11.16.4.1.5. Medical Evaluation (ME) for Military Duty Fact Sheet.

11.16.4.1.6. PEB Election.

11.16.4.1.7. PEB Fact Sheet.

11.16.4.1.8. AF Form 422.

11.16.4.1.9. Unit Commander Memorandum.

11.16.4.1.10. Member Utilization Questionnaire.

11.16.4.2. For ANG members:

11.16.4.2.1. Unit commander's endorsement.

11.16.4.2.2. SF 502, Narrative Summary must include:

11.16.4.2.2.1. Date and circumstance of occurrence.

11.16.4.2.2.2. Response to treatment.

11.16.4.2.2.3. Current clinical status.

11.16.4.2.2.4. Proposed treatment.

11.16.4.2.2.5. Current medications.

11.16.4.2.2.6. The extent to which the condition interferes with performance of military duty (see **Chapter 13**).

11.16.4.2.2.7. Prognosis.

11.16.4.2.3. Civilian medical documentation. Medical documentation from the member's civilian health care provider will be included in all waiver cases submitted on ANG members. The provider will review this information and reference it in the SF 502, Narrative Summary.

11.16.4.2.4. 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.

11.16.5. 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.

11.17. Failure to Complete Medical Requirements. ARC and ANG members who fail to complete medical/dental requirements are referred to their commanders in writing IAW AFMAN 36-8001, and are processed IAW AFI 36-3209.

11.17.1. Refusal. An ANG member 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.

Chapter 12

USAF REFRACTIVE SURGERY (USAF-RS) PROGRAM

Section 12A— General Information and Administrative Procedures

12.1. Applicability. This chapter applies to all AF AD/ARC personnel and establishes eligibility, procedures, restrictions and recording requirements for Air Force (AF) members participating in and supporting the USAF Refractive Surgery (USAF-RS) program. ANG Warfighters are exempt, refer to 12.2.2.1.

12.1.1. RS is not a TRICARE covered benefit. RS is intended to reduce operational disadvantages related to wear and care of spectacles and contact lenses by AF personnel. Though RS may be operationally beneficial in some personnel, it is an elective procedure. There is no requirement for any member or applicant to obtain any form of RS. Any individual planning RS must read and understand the benefits, limitations and risks associated with these procedures.

12.1.2. If applicable AF vision standards cannot be met following RS, the member may be disqualified from continued military service. AF AD/ARC members who undergo unauthorized RS treatment may be disqualified or restricted from certain duties.

12.1.3. AF personnel are separated into three Management Groups:

12.1.3.1. Trained "aviation and aviation-related special duty" (AASD) personnel.

12.1.3.2. Applicants to AASD.

12.1.3.3. Warfighter personnel.

12.1.4. AF AD and ARC Warfighters (eligible for AD elective surgery benefits) are authorized treatment at DoD RS centers and post-RS management at their military treatment facilities. Aviation and AASD/applicants are managed and authorized treatment as outlined in **Section 12D** and **Section 12E.**

12.1.5. ARC personnel who are not eligible for AD elective surgery benefits may undergo RS at their own expense at civilian centers. AD and ARC AASD members pursuing treatment at civilian RS centers must obtain written approval to proceed from the appropriate USAF-RS Program Manager prior to undergoing RS, and meet all pre- and post-operative requirements as detailed in **Section 12G**. ARC Warfighters are exempt from obtaining written approval to proceed from the appropriate USAF-RS Program Manager, but they must obtain permission from their immediate commander. Additional Air Force guidance for elective surgery is found in AFI 41-101, *Obtaining Alternative Medical and Dental Care*, AFI 41-210, and AFI 36-3003.

12.1.6. **Section 12B** defines inclusion criteria for the three Management Groups. For AASD Management Groups, members must meet both AFSC and ASC requirements. AF personnel who do not meet AASD criteria or have been permanently disqualified from AASD must comply with requirements of the Warfighter Management Group. A tool to assist in Management Group determination is available on the following website: AF KX

(DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**.

12.1.7. Each Management Group has specific USAF-RS requirements described in detail in **12D**, **12E** and **12F** respectively.

12.1.8. For the purpose of this guidance RS authorized for AASD only includes the following: Note: See Aircrew waiver guide for specific clinical guidelines.

12.1.8.1. Advanced Surface Ablation (ASA) procedures.

12.1.8.1.1. PRK.

12.1.8.1.2. LASEK.

12.1.8.1.3. Wave-Front Guided Photorefractive Keratectomy (WFG-PRK).

12.1.8.1.4. Epi-LASIK.

12.1.8.2. Intra-Stromal Ablation (ISA) procedures

12.1.8.2.1. Standard LASIK and its variants.

12.1.8.2.1.1. **DELETED**

12.1.8.2.2. Wave-Front Guided Laser In-Situ Keratomileusis (WFG-LASIK) - "custom ablation".

12.1.8.2.3. Technological advances of the basic LASIK procedure, such as femtosecond technology, "all laser LASIK".

12.1.9. The procedures listed in **12.1.8** are approved for Warfighters. Other FDA-approved RS procedures may be authorized for Warfighters based on guidance from the AF/SG Refractive Surgery Consultant. However, Radial Keratotomy (RK) is not approved.

12.1.10. Phototherapeutic keratectomy (PTK) is a therapeutic application of excimer laser technology used for diseases of the anterior cornea. In the context of this guidance, PTK is not an RS procedure. PTK is for medical management of corneal anomalies independent of the USAF-RS program.

12.1.11. RS re-treatment is considered a new treatment. Personnel who desire or require re-treatment must submit an application IAW with their management group requirements.

12.1.12. One of the goals of the USAF-RS program is to ensure RS treatment is prioritized in accordance with AF mission support. Prioritization categories are based on specific management groups and duty requirements. AF members seeking RS are assigned to one of these three priority categories:

12.1.12.1. Priority I: Personnel assigned to AF AASD career fields. Not included are permanently disqualified aircrew and/or former aviators who have cross-trained from aviation career duties.

12.1.12.2. Priority II: Personnel whose routine military duties require wear of NVG, eye protection, or respiratory protection. This does not include nuclear biological chemical (NBC) masks worn only for deployment.

12.1.12.3. Priority III: Personnel who do not meet any of the above criteria in his/her current AFSC.

Section 12B— Management Group Inclusion Criteria

12.2. Management group inclusion criteria. To ensure specific requirements are met, personnel are assigned to one of three USAF-RS Management Groups: Applicants to AASD, trained AASD, and Warfighter (all other AF personnel). Warfighter applications are managed by the Warfighter Program Manager (WPM) and AASD applications are managed by the Aviation Program Manager (APM). A tool to determine the appropriate RS management group is available at the AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**.

12.2.1. AASD management groups: (trained AASD and applicants to AASD).

12.2.1.1. Trained AASD members are identified by both AFSC and ASC requirements. AASD applicants are managed, after training selection, in accordance with their anticipated AFSC/ASC. Members who are permanently disqualified from AASD will be managed as a Warfighter.

12.2.1.2. The AASD management groups are for AF members whose primary duties involve in-flight and/or altitude chamber exposures including career aircrew who are temporarily assigned to non-flight duties, such as staff or educational duties, while remaining qualified to return to flight duty. Non-aviation AFSC personnel who are currently assigned to perform aviation-related duties, such as parachutists or flight test engineers, are also included. AASD personnel assigned to perform aviation-related duties are identified as part of the AASD management group as long as they remain qualified for their specific aviation-related duties. AASD personnel whose aviation-related duties are terminated or suspended will be managed as a Warfighter.

12.2.2. Warfighter management group:

12.2.2.1. Includes all other AF personnel not identified as applicant and trained AASD. **Note:** ANG Warfighters are exempt from the requirement to obtain permission to proceed with RS from the WPM. ANG AASD personnel must obtain permission to proceed with RS from the APM.

Section 12C— Responsibilities

12.3. AF member (AD or ARC) will:

12.3.1. Submit USAF-RS application, required supporting documentation/evaluation, and squadron commander's authorization, IAW specific management group requirements to the appropriate Program Manager, Warfighter Program Manager (WPM) for Warfighters or Aviation Program Manager (APM) for AASD.

12.3.2. Not proceed until specific management group requirements are met and "Permission to Proceed" is granted by the Program Manager (WPM/APM). Permission to proceed does not indicate member is approved for surgery. Permission to proceed means only that the member is authorized to proceed for surgical evaluation.

12.3.3. Read the FDA required refractive surgery informational booklet and material posted on the USAF-RS website (AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**) prior to RS evaluation.

12.3.4. Undergo only authorized USAF-RS procedures IAW this guidance.

12.3.5. Coordinate with and inform squadron commander, flight surgeon (FS)/PCM and AF eye clinic of USAF-RS application, treatment and required follow-up evaluations.

12.3.5.1. Member will not schedule RS at a time where surgery or recovery would interfere with an anticipated deployment cycle.

12.3.6. Notify FS/PCM and eye clinic that he/she has undergone USAF-RS within 1 week of RS procedure. This 1 week notification does not require an examination unless specifically indicated by an eye care provider.

12.4. Member's Squadron Commander will:

12.4.1. Maintain working understanding of USAF-RS program.

12.4.2. Grant or deny authorization for USAF-RS application based on best interests of AF. "Commander's Authorization" expires six months after the date of the signature.

12.4.3. Certify member meets AASD or Warfighter Management Group definition, has sufficient service retainability (minimum: 6 months – AASD, 6 months – Warfighter) and assign appropriate treatment prioritization (see para **12.1.12.1-3.).**

12.4.4. Authorize unit-funded TDYs for treatment at DoD facilities for eligible AD/ARC Pilots and AD/ARC in-flight refuelers. Non-pilot/in-flight refueler personnel may be authorized unit-funded or permissive TDY. Leave status is not authorized for treatment at DoD RS Centers. TDY en route for refractive surgery must be authorized only after coordination for follow-up care. **Note:** See AFI 36-3003 for further guidance.

12.4.5. Support operational restrictions following USAF-RS, as required.

12.4.6. Once returned to flying status, squadron commanders are strongly encouraged to require that post-CRS pilots accomplish the following sorties (as applicable to the unit's mission) with an instructor pilot in order to assure operational safety after CRS: first day and night sortie; first night refueling; first night formation flight.

12.5. FS PCM (AASD management groups) will:

12.5.1. Maintain working understanding of USAF-RS program.

12.5.2. Serve as point of contact for and monitor all AASD personnel during application, treatment and post-RS management to ensure program compliance.

12.5.3. Coordinate required RS-related evaluations with local eye care professional.

12.5.4. Accomplish appropriate grounding actions and waiver recommendations.

12.5.4.1. Submit aeromedical summary and all required waiver documentation in AIMWTS. Please see the waiver guide at: AF KX (DotMil): **https://kx.afms.mil/waiverguide** or (Public Access): **http://airforcemedicine.afms.mil/waiverguide**). Return to flight status before waiver completion is not authorized.

12.5.4.2. Initiate appropriate AF Form 469 as required. Member will not deploy or PCS until steroid eye drops have been discontinued and at least one month has passed since the date of surgery. Post-RS steroid treatment is co-managed by the treating surgeon and the local eye care provider and may be required for 4 months or longer.

12.5.4.3. PCS while on steroid eye drops may be authorized only after coordination for follow-up care due to the need to monitor the member's intraocular pressure. A co-managed care agreement must be signed by the gaining eye care provider before the member is authorized to PCS.

12.5.5. Provide squadron education briefings on USAF-RS policy. Briefings may be in conjunction with local eye care provider.

12.5.6. If the member's co-management is provided by a non-AF eye care provider, the PCM or local eye care provider is responsible for ensuring all copies of RS pre-operative, post-operative and RS related incident documents and any supporting documents, if required or requested, are entered electronically into AHLTA and a hard copy placed in the medical record following the same guidelines as for any other medical visit.

12.5.7. Report to USAF-RS APM aircrew grounded for unexpected RS-related events.

12.6. PCM (Warfighter Management Group) will:

12.6.1. Maintain working understanding of USAF-RS program.

12.6.2. Initiate appropriate AF Form 469 as required. Member will not deploy or PCS until steroid eye drops have been discontinued and at least one month has passed since the date of surgery. Post-RS steroid treatment is co-managed by the treating surgeon and the local eye care provider and may be required for 4 months or longer.

12.6.3. PCS while on steroid eye drops may be authorized only after coordination for follow-up care due to the need to monitor the member's intraocular pressure. A co-managed care agreement must be signed by the gaining eye care provider before the member is authorized to PCS.

12.6.4. If the member's co-management is provided by a non-AF eye care provider, the PCM or local eye care provider is responsible for ensuring all copies of RS pre-operative, post-operative and RS related incident documents and any supporting documents, if required or requested, are entered electronically into AHLTA and a hard copy placed in the medical record following the same guidelines as for any other medical visit.

12.7. Air Force Eye Care Provider will:

12.7.1. Maintain working understanding of USAF-RS program.

12.7.2. Serve as point of contact for Warfighter Management Group personnel during the RS application, treatment and post-RS management.

12.7.3. Monitor all RS-treated AF personnel; either by co-management with a DoD RS Center or by "Administrative Co-Management" for civilian treatments.

12.7.4. Attend the USAF-RS for Warfighters Workshop, offered by the USAF School of Aerospace Medicine, at the earliest possible opportunity based on local mission requirements. If local operational mission requirements prevent the AF eye care provider

from attending this training before beginning RS care, the AF eye care provider's unit commander must request a waiver from the USAF-RS APM. These waivers are valid until the next scheduled workshop. Refresher workshop attendance is highly recommended every 4 years at a minimum, or as directed by USAF-RS Consultant. For workshop information, visit the website: AF KX (DotMil): **https://kx.afms.mil/USAF-RS** (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**.

12.7.5. Coordinate and accomplish clinical screening, referral/application and post-RS evaluations IAW appropriate Management Group requirements.

12.7.5.1. Use AF-approved RS application and post-RS evaluation forms. Specific guidance regarding current approved forms is available on the website: AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**

12.7.5.2. Sign the co-managed care agreement for member's post-RS management/care before any RS is scheduled. If the co-managed care agreement expires prior to the intended surgery date, the co-managed care agreement must be re-accomplished. This is to ensure co-management services are available for the post-operative period.

12.7.5.3. Warfighter management:

12.7.5.3.1. Initiate and manage appropriate AF Form 469 in conjunction with member's PCM (as per **12.6.2**).

12.7.5.3.2. Certify member regarding RS-related duty restrictions and "Return to Duty" determinations. Vision Requirements based on Officer and Enlisted classification directory and this AFI. For clarification of any requirement, please examine these publications.

12.7.5.3.3. Notify applicable USAF PM and USAF RS Consultant of any RS complications/incidents. See AF/SG consultant listing on **https://kx.afms.mil/kxweb/dotmil/kj.do;jsessionid=DFBF21C7AA1E97BC880DAFC522D2EB1F?functionalArea=SGConsultants**.

12.7.5.4. AASD management:

12.7.5.4.1. Certify member regarding RS-related duty restrictions and AASD vision requirement status. Advise member's FS on aircrew's status for appropriate DNIF actions.

12.7.5.4.2. Report to FS and USAF-RS APM aircrew that require grounding for unexpected RS-related events.

12.7.6. Ensure all post-operative evaluations, reports and supporting documents are available for the flight surgeon's review through appropriate AHLTA documentation, supplemented by hard copies in the medical record when required. These forms must be available to the flight surgeon within the same guidelines as any other medical visit. For current post-op forms, see the refractive surgery website.

12.7.7. Support FS's squadron and professional staff education briefings on RS and related policies.

12.8. USAF-RS Centers will:

12.8.1. Comply with RS clinical practice guidelines published by USAF-RS consultant and posted on the AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**) and the Air Force Waiver Guide for AASD personnel.

12.8.2. Review and provide clinical quality control of RS documentation. Certify eligibility and ensure member has been authorized to undergo RS IAW appropriate management group.

12.8.3. Coordinate RS treatment.

12.8.3.1. Ensure a valid Managed Care Agreement and Commander's Authorization is on file for the member prior to scheduling RS treatment.**12.8.3.2** Verify applicant has "Permission to Proceed" authorization from the appropriate Program Manager **12.8.3.2**. Notify member and local eye care provider of clinical eligibility and coordinate scheduling for Warfighter applicants. Notify member, flight surgeon and local eye care provider of clinical eligibility and coordinate scheduling for AASD applicants. RS procedures for USAFA cadets will be accomplished at the USAFA Refractive Surgery Center.

12.8.3.2. All AF AD and ARC Trained AASD personnel eligible for AD elective surgery benefits are authorized treatment at any DoD RS center on either unit funded or PTDY IAW AFI 36-3003.

12.8.4. Accomplish final pre-operative clinical evaluation, final treatment decision/plan, informed consent documentation, RS treatment and initial follow-up.

12.8.4.1. Maintain a copy of all pre-operative, operative and post-operative documentation indefinitely IAW quality assurance guidance.

12.8.5. Report AASD RS-related complications and/or DNIFs to USAF-RS APM and USAF-RS Consultant, email and physical address located on the AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**.

12.8.6. Report Warfighter RS-related complications to WPM and USAF-RS Consultant. See AF/SG consultant listing on **https://kx.afms.mil/kxweb/dotmil/file/web/ctb_094132.pdf**

12.9. Waiver Authority (AASD Management Groups only) will:

12.9.1. Complete aircrew waiver actions in AIMWTS (as specified in the waiver guide at the AF KX (DotMil): **https://kx.afms.mil/waiverguide** or (Public Access): **http://airforcemedicine.afms.mil/waiverguide**.

12.9.2. Waiver and certification authority may not be delegated to local waiver authority.

12.9.3. Initial term of waiver validity will not exceed 1 year (twelve calendar months from the date of surgery); first waiver renewal will be for 1 year; second renewal may be for 2-3 years at waiver authority discretion.

12.10. USAF-RS Program Managers will:

12.10.1. Review all USAF-RS applications to ensure clinical guidelines, waiver criteria and administrative requirements are met. Grant "Permission to Proceed" if policy criteria are met or deny if policy criteria are not met.

12.10.2. For AASD personnel, notify member, member's flight surgeon and co-management eye care provider of member's application status.

12.10.3. Develop and maintain database of USAF-RS applications, post-RS evaluations and RS-related incidents.

12.10.4. Develop and review referral screening criteria with USAF-RS Consultant.

12.10.5. Develop and provide RS education for USAF-RS personnel with USAF-RS Consultant.

12.10.6. Provide updates on status of RS in AF personnel to HQ AF/SG3P to include statistics, trend analysis, conclusions and recommendations as appropriate.

12.11. USAF-RS Consultant will:

12.11.1. Coordinate procedures and management of all USAF-RS centers.

12.11.2. Develop and review USAF-RS Clinical Practice Guidelines. The guidelines will be available online at the USAF-RS website: AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**

12.11.3. Develop and review USAF-RS management referral criteria in coordination with USAF Aerospace Ophthalmology Consultant.

12.11.4. Develop and provide USAF-RS application, post-RS evaluation forms and related documents in conjunction with USAF Aerospace Ophthalmology Consultant.

12.11.5. Develop and maintain web-based information source on USAF-RS policy/program and related documents in conjunction with USAF Aerospace Ophthalmology Consultant. **12.11.6** Certify co-managing eye care providers in coordination with USAF Aerospace Opthalmology Consultant.

12.11.6. Certify co-managing eye care providers in coordination with USAF Aerospace Ophthalmology Consultant.

12.11.6.1. AF eye care providers will be certified by attending the USAF-RS for Warfighters Workshop. See paragraph **12.7.4**

12.11.6.2. Non-AF eye care providers will be certified by self-study and testing regarding AF RS policies and procedures. Study materials and test will be administered by the USAF Aerospace Ophthalmology Consultant. Intent of the self-study and testing is to ensure the non-AF eye care provider is aware of the RS procedures and deployment/PCS restrictions for all AF personnel with special emphasis on AASD members.

12.12. USAF Aerospace Ophthalmology Consultant will:

12.12.1. Develop and provide aviation RS application form, post-RS evaluation forms and related documents in coordination with the USAF-RS Consultant.

12.12.2. Accomplish advanced clinical pre- and post-op reviews and evaluations on AD/ARC pilots and in-flight refuelers IAW RS policy and the waiver guide.

12.12.3. Develop, validate and field quality-of-vision tests to assess visual performance after RS to assist in waiver processing of aircrew at the return-to-fly and waiver renewal points.

Tests must be coordinated and approved by USAF/SG3P Chief, Aerospace Medicine Policy and Operations.

12.12.4. Educate and certify AF eye care providers for RS management in conjunction with the USAF-RS Consultant.

12.12.5. Educate and certify non-AF eye care providers for RS co-management in conjunction with the USAF-RS Consultant. Certification will be designed to ensure co-managing eye care providers are aware of the appropriate guidelines and requirements for AF members, regardless of the Service providing the RS treatment or post-operative care.

12.12.6. Provide oversight and direction of USAF-RS for Warfighters Workshop in conjunction with the USAF-RS Consultant.

12.13. USAF/SG3P C hief, Aerospace Medicine Policy and Operations, or USAF/SG designee:

12.13.1. Provide USAF-RS policy and updates as required.

12.13.2. Provide updates on status of RS in AF personnel to HQ AF/SG.

Section 12D— Applicants to Aviation and Aviation-Related Special Duty (AASD)

12.14. Pre-RS Criteria. Applicants to AASD training programs (see **Section 12B** for AASD definitions) must follow requirements set in this chapter. After completion of flight training, guidance and requirements set in **Section 12E** must be met.

12.14.1. See USAF-RS Website for Clinical Criteria: AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS** and the Air Force Waiver Guide for specific guidance related to AASD personnel.

12.14.2. Documentation of pre-RS status must be provided.

12.15. Post RS Requirements and Waiver Process.

12.15.1. Applicant must be a minimum of 12 months post-RS for waiver disposition. Note: Applicant may begin waiver process no sooner than nine months post RS.

12.15.2. The examining FS must enter all pre- and post-RS documentation in the PEPP and AIMWTS, including the documentation of those applicants who are medically disqualified at the time of their initial flying class physical examination.

12.15.3. Aeromedical summary accompanying the initial physical examination must include documentation that all clinical criteria are met.

12.15.4. Read the waiver guide for specific post-RS requirements (Website: AF KX (DotMil): **https://kx.afms.mil/waiverguide** or (Public Access): **http://airforcemedicine.afms.mil/waiverguide**.

Section 12E—Trained Aviation and Aviation-Related Special Duty (AASD) Personnel: Note: See aircrew waiver guide for specific clinical guidelines.

12.16. Trained AASD RS Application Process.

12.16.1. AASD RS application information and required application form is available on-line at: AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**.

12.16.2. AD and ARC (eligible for AD elective surgery benefits) AASD personnel must have 6 months of retainability following planned RS treatment.

12.16.3. Read the FDA required refractive surgery informational booklet and material posted on the USAF-RS website AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**) prior to RS.

12.16.4. Member will submit all completed application and supporting documents to: The email or physical address found at: AF KX (DotMil): https://kx.afms.mil/USAF-RS or (Public Access): http://airforcemedicine.afms.mil/USAF-RS.

12.16.5. USAF-RS APM will review completed aviation RS application to ensure program policy criteria are met and issue permission to proceed or denied as appropriate.

12.16.6. USAF-RS APM will enter application data into USAF-RS database.

12.17. "Permission to Proceed" Information.

12.17.1. USAF-RS APM accomplishes "Permission to Proceed" determinations. The following categories are assigned:

12.17.1.1. Approved: "Permission to Proceed" is granted. Member is authorized to proceed with RS evaluation. Instructions to undergo RS evaluation will accompany this approval. Treatment must be completed within 6 months of the commander's signature on the command authorization form. The application process must be re-accomplished if member is unable to accomplish RS within this time period.

12.17.1.2. Denied: Applicant does not meet AASD personnel pre-RS criteria. Applicant is not authorized to undergo RS treatment IAW USAF-RS policies. Applicant may not undergo Warfighter or civilian RS unless authorized by USAF-RS APM. **Note**: Treatment under Warfighter policy or at a civilian facility, if previously denied under aviation policy, may result in permanent disqualification from future aviation duties.

12.17.2. USAF-RS "Permission to Proceed" determination document will be sent to the member with a copy to the member's FS and AF eye care provider by the APM. AASD member may not undergo RS prior to receipt of "Permission to Proceed" from the APM. It is the responsibility of the treating surgeon and AF member to ensure that this requirement is met.

12.17.3. All AF AD and ARC Trained AASD personnel eligible for AD elective surgery benefits are authorized treatment at any DoD RS center on either unit funded or PTDY IAW AFI 36-3003.

12.17.4. Trained AASD personnel who are not eligible for AD elective surgery benefits may undergo RS at their own expense at civilian centers and must take leave IAW AFI 36-3003 once "Permission to Proceed" from the APM has been granted.

12.17.5. No aviation personnel will receive monovision (one eye corrected for distance vision and the other corrected for near vision) refractive surgery.

12.17.6. FS will manage appropriate grounding actions and DLC.

12.18. "Return to Flight Status" Duties and Post RS/Waiver Requirements.

12.18.1. Read the waiver guide for specific post-RS requirements (Website: AF KX (DotMil): **https://kx.afms.mil/waiverguide** or (Public Access): **http://airforcemedicine.afms.mil/waiverguide**.

12.18.2. Member must complete post-RS evaluation as defined in the waiver guide. Failure to comply with evaluations and submission of documentation may result in grounding (DNIF) until requirements are met.

12.18.3. ARC members, unless eligible for AD medical care benefits, must accomplish required post-RS evaluations at own expense from civilian RS provider. Copies of post-RS evaluation must be provided and entered into member's AF medical record.

12.18.4. The member's flight surgeon will submit aeromedical summary and all required waiver documentation in AIMWTS (per the waiver guide) for forwarding to the waiver authority. Waiver authority will not grant any waivers until all required information is received in AIMWTS and made available to the USAF-RS APM. Note: Return to flying status with a local AF Form 1042 prior to waiver approval by the waiver authority is not authorized.

12.18.5. Any visual complaints, surgical complications, post-surgical incidents, or recommended duty restrictions must be documented in the medical record, and included in the post-RS evaluation documentation and submitted via AIMWTS at initial waiver or waiver renewal.

12.18.6. If corrective lenses are required to meet applicable vision standards, they must be prescribed and worn. Contact lens wearers must carry spectacle back-ups when flying IAW the Aircrew Contact Lens Program Policy. If NVG are required for the duty position, applicable NVG vision standards must be met.

12.18.7. Member will not deploy or PCS while on steroid eye drops after any RS procedure. Individuals will not be eligible for deployment until steroid eye drops are discontinued and at least 1-month has passed from the date of surgery.

12.18.7.1. Member will not schedule RS at a time where surgery or recovery would interfere with an anticipated deployment cycle.

12.19. Post-RS Requirements.

12.19.1. Follow-ups must be accomplished IAW USAF-RS website AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**.

Section 12F— Warfighter Personnel

12.19. Warfighter RS Application Process. All AF personnel not specifically managed IAW AASD requirements must comply with Warfighter management group requirements.

12.19.1. Member will obtain Squadron Commander's authorization form and application form posted on the USAF-RS website AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**

12.19.2. AD and ARC (eligible for AD elective surgery benefits) personnel must have 6 months of retainability following planned RS treatment.

12.19.3. AD and eligible ARC members may obtain approved RS procedures at any DoD RS Center. DoD RS Centers will contact member regarding approval and schedule appointment for RS.

12.19.4. For ARC personnel not eligible to receive elective surgery at AF medical treatment facilities or AD personnel electing civilian treatment, the member must obtain the RS and follow-up at their own expense.

12.20. "Permission to Proceed" Information.

12.20.1. Warfighter personnel undergoing RS in Warfighter management may travel on permissive TDY or unit-funded TDY status IAW AFI 36-3003. RS planned during TDY en route with a PCS is authorized only after coordination for follow-up care from the gaining base. Leave status is not authorized for treatment at DoD RS Centers.

12.20.2. Warfighters eligible for AD elective surgery may be treated at any DoD RS Center. Coordination for treatment is managed by the member. The member's squadron commander must grant permission for USAF-RS prior to treatment.

12.20.3. Warfighters not eligible for AD elective surgery benefits are authorized civilian RS treatment/follow-up at his/her own expense within the guidelines set in AFI 41-210 (electing optional medical care). Application and any supporting documentation must be accomplished and submitted as set forth in this policy. USAF- RS WPM must grant "Permission to Proceed" as below.

12.20.4. USAF-RS WPM accomplishes "Permission to Proceed" determinations. The following categories are assigned:

12.20.4.1. Approved: ("Permission to Proceed" is granted). Member is authorized to proceed with RS evaluation. Instructions to undergo RS treatment will accompany this approval. Treatment must be completed within 6 months of the commander's approval date. The application process must be re-accomplished if member is unable to accomplish RS within this time period.

12.20.4.2. Denied: (Applicant does not meet pre-RS criteria). Applicant is not authorized to undergo RS treatment IAW USAF-RS policy. Applicant may not undergo Warfighter or civilian RS unless authorized by USAF-RS WPM. Note: Treatment at a civilian facility, if previously denied under USAF-RS policy, may result in permanent disqualification from military duties.

12.20.5. USAF-RS "Permission to Proceed" determination document will be sent to the member with a copy to the member's AF eye care provider. Member may not undergo RS prior to receipt of an approved "Permission to Proceed" document. It is the responsibility of the treating surgeon and AF member to insure that this requirement is met.

12.21. "Return to Duty" Requirements.

12.21.1. The AF local eye care provider in conjunction with the member's PCM must initiate an appropriate DLC when the member returns from an RS procedure. The DLC will be managed by member's PCM in coordination with the local eye care clinic. Member will not deploy or PCS while on steroid eye drops after any RS procedure. Individuals will not be eligible for deployment until steroid eye drops are discontinued and at least 1-month has passed from the date of surgery.

12.21.2. All personnel undergoing RS must be evaluated by a DoD eye care provider in order to be cleared to resume unrestricted duties.

12.21.3. Member may return to limited duty (but is still not deployable) within a few days after surgery as recommended by the local eye care provider.

12.21.4. Individual must meet the applicable USAF vision standards in Chapter 5, before returning to full duty. If corrective lenses are required to meet the applicable vision standards, they must be prescribed and worn. Contact lens wearers must have spectacle back-up. If NVG are required for the duty position, applicable NVG vision standards must be met.

12.22. Post-RS Requirements.

12.22.1. Follow-ups must be accomplished IAW USAF-RS website AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**. Local RS follow-up must be accomplished by the MTF, prioritized IAW AFI 41-115.

12.22. Post-RS Requirements.

Section 12G—Air Force Personnel Seeking RS at a Civilian Treatment Center

12.23. Civilian RS application process. AF members (AD or ARC) not eligible for AD elective surgery benefits or electing to pursue civilian treatment are authorized to obtain RS and follow-up care at their own expense. Additional AF guidance for elective surgery is found in AFI 41-101, AFI 41-210, AFI 36-3003 and DoDI 1332.39.

12.24. Civilian RS application information, required application form, and other supporting documents are available on-line at: AF KX (DotMil): https://kx.afms.mil/USAF-RS or (Public Access): http://airforcemedicine.afms.mil/USAF-RS.

12.25. AF Member's responsibilities.

12.25.1. Submit USAF-RS application and required supporting documentation and evaluation to include Commander's Authorization Form. If civilian treatment is desired, ensure the Administrative Monitoring Agreement for Civilian Treatment and Managed Care Agreement for Civilian Treatment forms are included with the application IAW specific management group requirements.

12.25.2. Not proceed with or schedule surgery until specific management group requirements are met and "Permission to Proceed" authorization from the appropriate USAF-RS Program Manager is granted.

12.25.3. Read the FDA required refractive surgery informational booklet and material posted on the USAF-RS website (AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS**) prior to RS.

12.25.4. Undergo authorized USAF-RS procedures IAW this guidance and receive all follow-up care by civilian RS center at their own expense.

12.25.5. Coordinate with and inform squadron commander, FS/PCM and AF eye clinic of USAF-RS application, treatment and follow-up evaluations, as required. Notify FS/PCM and AF eye clinic that he/she has undergone USAF-RS within 1 week of RS procedure.

12.25.6. Comply with and accomplish all required referral and follow-up evaluations. Non-compliance may result in duty restrictions and/or disqualification.

12.25.7. Provide a copy of all pre-operative evaluations, surgical reports, and follow-up exams performed by the civilian RS center for inclusion in military medical records.

12.26. FS/PCM responsibilities.

12.26.1. In coordination with the patient's eye care provider:

12.26.1.1. Initiate an AF Form 469.

12.26.1.2. Evaluate the member to determine if USAF Vision Standards are met IAW Chapter 5.

12.26.2. Notify the appropriate USAF-RS Program Manager of any RS-related complications or incidents per clinical practice guidelines.

12.27. "Permission to Proceed for RS evaluation". Note: To ensure specific requirements are met, personnel are assigned to one of three USAF-RS Management Groups: Applicants to AASD, trained AASD, and Warfighter (all other AF personnel). Warfighter applications are managed by the Warfighter Program Manager (WPM) and AASD applications are managed by the Aviation Program Manager (APM). A tool to determine the appropriate RS management group is available at the AF KX (DotMil): **https://kx.afms.mil/USAF-RS** or (Public Access): **http://airforcemedicine.afms.mil/USAF-RS.12.27.1**. WPM or APM accomplishes "Permission to Proceed for RS Evaluation" determinations. The following categories are assigned:

12.27.1.1. Approved: ("Permission to Proceed" is granted). Member is authorized to proceed with RS evaluation for surgery at the civilian laser center. Instructions to undergo RS evaluation will accompany this approval. Evaluation and surgery must be completed within 6 months of the commander's authorization date of signature. The application process must be re-accomplished if member is unable to accomplish RS within this time period.

12.27.1.2. Denied: (Applicant does not meet USAF pre-RS criteria). Applicant is not authorized to undergo RS treatment IAW USAF-RS policies. Applicant may not undergo civilian RS unless authorized by appropriate USAF-RS program manager. Note: Treatment at a civilian facility, if previously denied by USAF policy, may result in duty restrictions and/or permanent disqualification from future aviation duties.

12.27.1.3. Pending: Applicant must supply additional administrative and/or clinical documentation prior to permission status determination.

Chapter 13

MOBILITY STATUS AND DEPLOYMENT CRITERIA

Section 13A— General Considerations

13.1. 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 deployment or TDY for six months in field conditions. A fitness for deployment determination is an assessment of current medical condition. A deployment is defined as any temporary duty where Contingency, Exercise, and Deployment temporary duty (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 further information. Note: For DoD civilian employees, DoD Directive 1400.31, *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, *Contractor Personnel Authorized to Accompany the U.S. Armed Forces*.

13.1.1. 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.

13.1.2. The standards listed in 13.2. are the minimum necessary to maintain mobility status, and are listed in addition to the accession, retention, and general fitness for duty standards. The standards also will be applied to any deploying active duty or ARC member, including members who have completed either a MEB, PEB or assignment limitation code fast track. Any individual, who cannot maintain mobility status for a chronic or recurrent medical condition must meet an MEB or assignment limitation code fast track. **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*.

13.1.3. ARC members must have deployment criteria addressed in the Narrative Summary submitted in the Worldwide Duty Medical Evaluation package for the purpose of enabling the ARC/SG to make a valid deployability determination. The provider submitting the request must consider the standards in **13.2** in the narrative summary.

13.2. Standards. To be deployable**,** an individual must:

13.2.1. Be able to perform duties for a prolonged period (12 hours or more).

13.2.2. Be able to subsist on field rations for up to four months.

13.2.3. Be free of medical conditions, including pregnancy, which require special appliances, or frequent treatment or follow up by medical specialists or sub specialists not readily available in theater. Any chronic medical condition that fails to respond to adequate conservative treatment or that necessitates significant limitation of physical activity must be considered non-deployable.

13.2.3.1. 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 (See 5.3.20.7.)

13.2.4. Be free of physical or psychological conditions resulting in the inability to wear or use all required items of uniform or personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical/biological protective garments, regardless of the nature of the underlying condition if wearing such equipment can be reasonably anticipated or required in the deployed location.

13.2.5. Be able to perform heavy physical work over at least short periods of time. This includes the ability to carry all required deployment baggage (at least 40 lbs) and to run at least 100 yards.

13.2.6. Have adequate unaided hearing to perform duties safely. The requirement for use of hearing aids does not necessarily preclude deployment or mobility status.

13.2.7. Have adequate night vision to be able to travel unassisted at night.

13.2.8. Have corrected visual acuity that is sufficient to meet job requirements and safely perform duty.

13.2.9. Be able to perform duties in hot and cold environments.

13.2.10. Be free of any medical condition that could result in sudden incapacitation, including a history of stroke within the last 24 months, seizure disorders and diabetes mellitus, requiring any medication for control. No recurrent loss of consciousness for any reason.

13.2.11. Be able to travel by air, land or sea.

13.2.12. Must be free from conditions that preclude or limit certain immunizations or use of force health protection prescription products required for the specific deployment. Depending on the applicable threat assessment required force health protection products may include: atropine, epinephrine, and/or 2-pam chloride auto-injectors, certain antimicrobials, antimalarials, and pyridostigmine bromide. Any military member with a vaccination allergy must be evaluated by a credentialed military allergist to determine limitations in vaccination receipt. **Note**: Individuals who are unable to receive the smallpox vaccine before relocation may still be qualified for duty in areas that are identified as a higher threat for smallpox since vaccination can be given up to four days after exposure. The decision to deploy or assign personnel who cannot be pre-vaccinated against smallpox must be based on theater or NAF policies or, where allowed, local commander consideration of factors such as risks to the individual and the mission.

13.2.13. Be free from active tuberculosis or known blood-borne disease that may be transmitted to others in a deployed environment. **Note**: Before a member with a diagnosis of HIV seropositivity with progressive clinical illness or immunological deficiency is deployed, the gaining Combatant Command Surgeon must be consulted and grant medical clearance for deployment per DoD policy.

13.2.14. Not have a history of myocardial infarction, coronary artery bypass graft, coronary artery angioplasty, carotid endarterectomy, other arterial stenting or aneurysm repair within one year of deployment.

13.2.15. Not have symptomatic coronary artery disease.

13.2.16. Not have cardiac dysrhythmias or arrhythmias, either symptomatic or requiring medical or electrophysiologic control (presence of an implanted defibrillator and/or pacemaker).

13.2.17. Not have heart failure or hypertension not controlled with medication or that requires frequent monitoring.

13.2.18. Have a dental exam within the last 12 months, not be likely to require dental treatment or reevaluation for oral conditions that will result in dental emergencies within 12 months. **Note**: Individuals being evaluated by a non-DoD civilian dentist must use a DD Form 2813, DoD Active Duty/Reserve Forces Dental Examination, as proof of dental examination. **Note**: See AFI 10-250, *Individual Medical Readiness*, 2.3.2.6 and AFI 47-101, 6.10.5.3 for additional guidance.

13.2.19. Not have a history of Psychotic and/or bipolar disorders, requiring ongoing treatment with antipsychotics, lithium, or anticonvulsants. Member must not experience residual symptoms that impair duty performance nor suffer from a condition which would pose a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment.

13.2.19.1. Other psychiatric disorders requiring treatment or frequent follow-up must have at least three months of demonstrated stability before they can be considered deployable.

13.3. Non-mobility status personnel (ALC-C1, 2, 3 or LAS or ANG members with a condition waived for worldwide duty) who have existing medical conditions may deploy if all of the following conditions are met.

13.3.1. 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.

13.3.2. 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.

13.3.3. 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.

13.3.4. There is no need for, 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).

13.3.5. 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).

13.3.6. Coordination with deployed commanders (or delegated waiver authority) may be required based on current conditions, host nation requirements or changing mission requirements.

13.4. Personnel with the following conditions may not deploy.

13.4.1. Cancer for which the individual is receiving continued treatment or requiring specialty medical evaluations during the anticipated duration of the deployment.

13.4.2. Precancerous lesions (e.g. cervical dysplasia) that have not been treated and/or evaluated and that require treatment and/or evaluation during the anticipated duration of the deployment.

13.4.3. Any musculoskeletal condition that significantly impairs performance of duties in a deployed environment.

13.4.4. Any medical condition that requires surgery or for which surgery has been performed that requires rehabilitation or additional surgery to remove devices.

13.5. Adopted Forms.

DD 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 2766, Adult Preventive and Chronic Care Flowsheet

DD Form 2807-1,*Report of Medical History*

DD 2808, Report of Medical Examination

DD Form 2813, DoD Active Duty/Reserve Forces Dental Examination

SF 78, Certificate of Medical Examination

SF 88, Medical Record – Report of Medical Examination

SF 93, Report of Medical History

SF 507, Clinical Record-Continuation Sheet

SF 515, Medical Record – Tissue Examination

SF 600, Medical Record – Chronological Record of Medical Care

AF Form 469, *Duty Limiting Conditions Report*

AF Form 422, *Physical Profile Serial Report*

AF 1041, Medical Recommendation for Flying or Special Operational Duty Log

AF 1042, Recommendation for Flying or Special Operation Duty

AF 1139, Request for Tumor Board Appraisal and Recommendation

AF 1480A, Adult Preventive and Chronic Care Flowsheet

AF IMT 847, Recommendation for Change of Publication

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Attachment 1

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Abbreviations and Acronyms

ACS— Aeromedical Consultation Service

ACSCL— Aircrew Soft Contact Lens

ADHD— Attention Deficit Hyperactivity Disorder

AETC— Air Education and Training Command

AFCITA— Air Force Complete Immunization Tracking Application

AFI— Air Force Instruction

AFIP— Armed Forces Institute of Pathology

AFMSA—Air Force Medical Support Agency

AFPC— Air Force Personnel Center

AFRC— Air Force Reserve Command

AFROTC— Air Force Reserve Officer's Training Corps

AFSC— Air Force Specialty Code

AGE— Arterial Gas Embolism

AGR— Active Guard Reserve

AIA— Air Intelligence Agency

AIMWTS— Aeromedical Information Management Waiver Tracking System

ALC C— Assignment Limitation Code C

ALC—FT – Assignment Limitation Code Fast Track

ALC—R – Assignment Limitation Code Request

AMP— Aerospace Medicine Primary

AMS— Aeromedical Summary

ANG— Air National Guard

ANSI— American National Standards Institute

APM— Aviation Program Manager

ARC— Air Reserve Components (ANG, IMA and unit reservists)

AR—GBC – Adaptability Rating for Control Duty

ARMA— Adaptability Rating Military Aviation

ARC SURGEON— HQ AFRC/SGP for unit assigned and IMA members of the Air Force Reserve; ANG/SGP for guardsmen

ARPC— Air Reserve Personnel Center

AR—SMOD – Adaptability Rating for Space and Missile Operations Duty

ASA— Air Sovereignty Alert

ASC— Aviation Service Code

AV— Atrioventricular

BETS— Benign Epileptiform Transients

BMR— Basic Mission Ready

BMTS— Basic Military Training School

BOT— Basic Officer Training

CBC— Complete Blood Count

CCT— Combat Control Team

CL— Contact Lenses

cm— Centimeter

CMR— Combat Mission Ready

CNS— Central Nervous System

CONUS— Continental United States

COT— Commissioned Officer Training

CRO— Combat Rescue Officer

CRT— Corneal refractive therapy

CTT— Color Threshold Tester

DAWG— Deployment Availability Working Group

dB— Decibel

DCS— Decompression Sickness

DF— Dean of Faculty

DLI— Defense Language Institute

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

ECG— Electrocardiogram

EEG—Electroencephalogram

EPTS— Existing Prior to Service

FAA— Federal Aviation Administration

FALANT— Farnsworth lantern test

FC— Flying Class

FDA— Food and Drug Administration

FEB— Flying Evaluation Board

FFD— Fitness for Duty

FHM— Force Health Management

FS— Flight Surgeon

FSO— Flight Surgeon's Office

GBC— Ground Based Controller

G-LOC— G induced loss of consciousness

G6PD— Glucose-6-phosphate dehydrogenase

HALO— High Altitude-Low Opening

HARM— Host Aviation Resource Management Office

HDL— High-density lipoprotein

HIPAA— Health Insurance Portability and Accountability Act

HIV— Human Immunodeficiency Virus

HPSP— Health Professions Scholarship Program

HQ AFRC/SGP— Headquarters Air Force Reserve Command, Aerospace Medicine Division

HQ USAF/SG— Headquarters United States Air Force Surgeon General

ICD— International Classification of Disease

IDT— Inactive Duty for Training

IMA— Individual Mobilization Augmentee

IMR— Individual Medical Readiness

INTACS— corneal implants

IOP— Intraocular Pressure

IRR— Individual Ready Reserve

(ITO)— Invitational Travel Orders

JSCET— Joint Security Cooperation Education and Training

KEAS— Knots Equivalent Air Speed

KX— Knowledge Exchange

LASEK— Laser Epithelial Keratomileusis

LASIK— Laser-Assisted In Situ Keratomileusis

LEP— Laser Eye Protection (LEP):

LOC— Loss of consciousness

MAJCOM— Major Command

MC— Medical Corps

MEB— Medical Evaluation Board

MEPS— Military Entrance Processing Station

MFS— Medical Flight Screening

mm— Millimeter

mmHg— Millimeters of mercury

MPF— Military Personnel Flight

MPS— Military Personnel Section

MP—UAS – Man Portable- Unmanned Aircraft System

MRI— Magnetic Resonance Imaging

MTF— Medical Treatment Facility

MUGA— Multiple Gated Acquisition

NATO— North Atlantic Treaty Organization

NBC— Nuclear Biological Chemical

NOMI— Naval Operational Medicine Institute

NVD— Night Vision Devices

OEHME— Occupational and Environmental Health Medical Examinations

OEHWG— Occupational and Environmental Health Working Group

OGTT— Oral Glucose Tolerance Test

OTC— Over the Counter

OVT— Optec Vision Tester

PC— Point of convergence

PCM— Primary Care Manager

PCS— Permanent Change of Station

PDA— Patent Ductus Arteriosus

PDS— Pigmentary Dispersion Syndrome

PEB— Physical Evaluation Board

PEBLO— Physical Evaluation Board Liaison Officer

PEO— Program Executive Officer

PEPP— Physical Examination and Processing Program

PGS— Pigmentary Glaucoma Suspect

PHA— Preventative Health Assessment

PHI— Protected Health Information

PIM— Pre-trained Individual Manpower

PIMR— Preventive Health Assessment And Individual Medical Readiness

PIP— Pseudoisochromatic Plates

PK— Penetrating Keratoplasty

PRK— Photorefractive Keratectomy

PSR— Patient Status Report

PTK— Phototherapeutic Keratectomy

RAT—- Reading Aloud Test

RD— Reinforcement designees

RDS— Records Disposition Schedule

RILO— Review in Lieu of

RK— Radial Keratotomy

RMU— Reserve Medical Unit

ROTC— Reserve Officer Training Corps

RPA— Remotely Piloted Aircraft

RPR— Rapid plasma regain

RPW— Repatriated Prisoner of War

RTD— Return to Duty

RTFS— Return to Flying Status

SAT— Strength Aptitude Test

SCETP— Security Cooperation Education and Training Program (SCETP)

SCL— Soft Contact Lenses

SCUBA— Self Contained Underwater Breathing Apparatus

SMOD— Space and Missile Operations Duty

SOD— Special Operational Duty

SOF— Supervisor of Flying

SRTS— Spectacle Request Transmission System

SSS— Small Sharp Spikes

SUAS—O – Small Unmanned Aircraft Systems Operators

SUPT—- Specialized Undergraduate Pilot Training

TDRL— Temporary Disability Retirement List

TDY— Temporary Duty

TPSK— Topographical Pattern Suggestive of Keratoconus

UAS— Unmanned Aircraft System

UDS— Urine Drug Screen

UFT— Undergraduate Flying Training

UNT— Undergraduate Navigator Training

UPT— Undergraduate Pilot Training

USAFA— United States Air Force Academy

USAFR— United States Air Force Reserve. Includes unit assigned reservists and Individual Mobilization Augmentees (IMA)

USAFSAM/FECA— United States Air Force School of Aerospace Medicine/Department of Aerospace Medicine, Clinical Sciences Division, Aerospace Medicine Branch

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

WPM— Warfighter Program Manager

WWD— Worldwide Duty

VDRL— Venereal Disease Research Laboratory

Attachment 2

*CERTIFICATION AND WAIVER AUTHORITY

Table A2.1. Certification & Waiver Authority.

Attachment 2 Table A2.1. Certification & Waiver Authority		
Category	**Certification Authority** Notes: 8, 9, 11, 12, 14, 15, 17, 24	**Waiver Authority** Notes: 1, 2, 8, 10, 11, 12, 14, 17, 20, 21, 22, 23, 24, 25
Flying Class I, IA,MFS, Note 16	AETC/SGPS	AETC/SGPS
ANG Flying Class I/MFS/IA	AETC/SGPS	AETC/SGPS
Initial FCII (Note 16)		
Active Duty	AETC/SGPS	AETC/SGPS
Reserves	AFRC/SG Note 6	AETC/SGPS
ANG	ANG/SG Note 6	AETC/SGPS
Periodic Flying Class II Notes 3, 4, 5, 6, 10, 23		MAJCOM/SG Note 17, 24
Flying Class III (Notes 7, 16, 23)		
Initial (Active Duty)	AETC/SGPS	AETC/SGPS
Initial (Reserves)	AFRC/SG Note 12	AFRC/SG
Initial (ANG)	State Air Surgeon (ANG) Note 12	ANG/SG
Continued Flying (All)		MAJCOM/SG See paragraph 6.4.15.
Special Operational Duty		
Initial Note 16	MAJCOM/SG	AETC/SGPS
Continued Special Operational Duty	Appropriate ARC SG Note 17	MAJCOM/SG
Flying Class IIU	AETC/SGPS	AFMSA/SG3PF
Continued IIU Duty		AFMSA/SG3PF
Physiological Training (ASC 9W/Operational Support Duty (ASC 9C)		
Active Duty	Local SGP	Local SGP
Reserves	Local SGP	Local SGP Note 25
ANG	State Air Surgeon (ANG) Note 17	State Air Surgeon (ANG) Note 17
Space & Missile Operations Duty		
Active Duty	AFSPC/SG	AFSPC/SG

		AFGSC/SG (for SMOD in their command)
Continued Duty		AFSPC/SG
Reserves	AFSPC/SG	AFSPC/SG
		AFGSC/SG (for SMOD in their command)
ANG	State Air Surgeon ANG Note 17	AFSPC/SG
		AFGSC/SG (for SMOD in their command)
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		
Extended Active Duty	AETC/SGPS	AETC/SGPS
Reserves	MEPS for non-prior service AFRC/SG for prior service	AFRC/SG
ANG	MEPS	ANG/SG
USAFA	USAFA/SG	USAFA/SG
Change In Commission Status without Break in Service		
Active Duty	Note 14	AFPC/DPAMM
Reserve Program	AFRC/SG (Note 13)	AFRC/SG
ANG	State Air Surgeon (ANG) (Note 17)	ANG/SG
Officer Program Applicants		
USAFA	DODMERB	USAFA/SG
ROTC	DODMERB	AETC/SGPS
USUHS	DODMERB	ASD (HA)
HPSP	AETC/SGPS	AETC/SGPS
Special Officer Procurement	AETC/SGPS	AETC/SGPS
AF Initial Enlistment (See paragraph 1.2.1.2.1.		
Active Duty	MEPS	AETC/SGPS
Reserves	Local SGP (IRR only) or MEPS	AFRC/SG
ANG	MEPS	ANG/SG
Continued Military Service/WWD following MEB		

Active Duty (MEB)	AFPC/DPAMM	
Reserves		AFRC/SG
ANG		ANG/SG
Return to Active Duty following break in service (greater than six months)	AETC/SGPS	AETC/SGPS
Recall to Active Duty ARC		AFPC/DPAMM
Palace Chase or Front Note 26		
Reserves	Reserve Medical Unit	AFRC/SG Note 19
ANG	ANG Medical Group	ANG/SG
AGR Tours		
Base Level AGR tour (ANG Title 32)		
Reserves	Reserve Medical Unit Note 18	ARC SG Note 17
ANG	State Air Surgeon (ANG) Note 17	ANG/SG
MAJCOM Level AGR Tour (ANG Title 10)		
Reserves	AFRC/SG	AFRC/SG
ANG	ANG/SG	ANG/SG
Parachute Duties, Static Line, Army Airborne Training		
Initial	Local SGP	AETC/SGPS
Continued		MAJCOM/SG
Static Line Training Only		
Reserves	AFRC/SG	AETC/SGPS
ANG	State Air Surgeon (ANG) Note 17	AETC/SGPS
RPA Sensor Operators		
RPA Sensor Operators (IU)	AETC/SGPF	AETC/SGPS
RPA Sensor Operators (1U) Continued Duty		MAJCOM/SG
Ground Based Controllers		
Initial	Local SGP	AETC/SGPS
Continued		MAJCOM/SG
Reserves	AFRC/SG	AETC/SGPS
ANG	State Air Surgeon (ANG) Note 17	AETC/SGPS

Notes:

1. For cases in which AF/SG3PF is waiver authority, interim waiver authority by subordinate commands is specifically denied. See Paragraph 6.4. for additional information.

2. AF/SG (Headquarters United States Air Force Surgeon General) is the ultimate waiver authority for all medical waivers. AF/SG has delegated waiver authority to AF/SG3PF, specifically to the USAF Consultant for Aerospace Medicine. Other delegation of certification or waiver authority is only as designated in this instruction.

*3. Authority to grant categorical Flying Class II with suffixes A, B, or C and IIU and Flying Class III waivers with scanning restrictions is retained by AF/SG3PF, unless delegated in this AFI or re-delegation memorandum.

3.1. Exceptions.

3.1.1. Flying Class IIA. MAJCOM/SG may grant the following FCIIA waivers:

3.1.1.2. Initial and renewal for asymptomatic moderate aortic insufficiency (AI) or with otherwise non-disqualifying ventricular dysrhythmias, which are considered possibly related to AI (no evidence of left ventricular enlargement or dysfunction) for members seen or case, reviewed at the ACS.

3.1.1.3. Initial and renewal for Minimal Coronary Artery Disease (MCAD) for members seen or case reviewed at the ACS.

3.1.1.4. Initial waiver for Aerospace Medicine Primary (AMP) course applicants who possess color vision deficiency is delegated to AETC/SG.

3.1.2. Flying Class IIB. MAJCOM/SG may grant renewals only for waivers initially granted by AF/SG3PF.

3.1.3. Flying Class IIC. MAJCOM/SG may grant initial waiver (and renewal) only for the following:

3.1.3.1. H-3 Profile (inactive flyers). The following restriction applies: “An occupational cockpit hearing evaluation/assessment is required prior to reassignment to active flying.”

3.1.3.2. Pregnancy. AF/SG3PF has delegated this waiver to the MAJCOM who may delegate further if desired.

*3.1.4. Other. MAJCOM/SG may grant initial and renewal waivers for all routine ACS clinical management group evaluations as defined by the ACS. Controversial cases will be forwarded to AF/SG3PF. MAJCOM/SG will forward a copy of all FCIIA/B/C actions (memorandum cover letter) as follows: FCIIA, B, or C: forward copy to AFPC/DPAOT3, 550 C Street West Ste 31, Randolph AFB, TX 78150. Colonel (0-6) forward copy to: AFSLMO/CA, 2221 S. Clark Street, Crystal Plaza 6, Ste 500, Arlington, VA 22202. All FCIIC waiver actions delegated to MAJCOM/SG require memorandum cover letter by MAJCOM/SG be forwarded to AF/SG3PF, 1500 Wilson Blvd, Suite 1600, Arlington, VA, 22209 and USAF/A3OT, 1480 AF Pentagon Washington, DC 20032-1480, to include FCIIC waiver renewals. Ensure the restrictions are contained in the memorandum. **Note**: ARC does not have the requirement to forward FCIIA, FCIIB, and FCIIC waivers to AFPC/DPAO.

4. Certification and waiver authority for USAF flying personnel while assigned to the National Aeronautics and Space Administration (NASA) is NASA.

*5. AFMC/SG has certification and waiver authority on USAF Test Pilot School/Flight Test Engineer applicants, except as noted in 6.4. May be further delegated at AFMC/SG discretion.

6. AFRC SG and ANG/SG is the certification authority for their assigned personnel who apply for the AMP course.

*7. Non-rated applicants for flying duty (Class III) and Flight Nurse applicants, who are currently medically qualified and performing flying duty, do not require additional review and certification or reexamination prior to retraining unless the individual is applying for Inflight Refueling Duty, SERE Specialist, Combat Control Duty, Pararescue Duty, Combat Rescue Officer, or the individual is on a medical waiver. **Note**: Enlisted members applying for commissioning may use their most current PHA and completed AF Form 422 noting qualified for GMS, Commission and Retention, in lieu of accomplishing another physical for the specific purpose of commissioning. A current AF Form 422 must accompany all cross-training applications.

*8. The authority for ANG is ANG/SG; the authority for Reservists (all categories) is AFRC/SG.

*9. AETC/SGPS is the certification authority for those individuals undergoing Basic Military Training School (BMTS). For ARC members undergoing BMTS, ARC SG will coordinate medical disposition.

10. Responsibility for medical waivers has been delegated as follows: Air Force District of Washington (AFDW) is delegated to AMC/SGPA: 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. (to include Notes), will be the medical facility's MAJCOM/SG that submits the aeromedical waiver examination package. Waiver authority for AFIA is delegated to AFIA/SG when that position is filled by a RAM. 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.

11. Medical waiver authority has been delegated to the MAJCOM to which the member is assigned for duty (e.g., member's MAJCOM is ACC, but they are assigned PCS to USAFE, PACAF, etc., for duty, that MAJCOM becomes the certification and waiver authority in accordance with Table A2.1.).

12. AETC/SGPS is sole certification and waiver authority for applicants applying for the Combat Control, Combat Rescue Officer or Pararescue Duty career fields.

13. Applicants who previously held a commission for 6 months or more in any service component and who are within 6 months of separation or non-participant status, will not require their physical exam to be reviewed or certified by AFRC/SG prior to being commissioned in the reserve program, unless the applicant does not meet the medical requirements IAW AFI 48-123,

Chapter 5.

14. Local Base Certification/Waiver Authority (active duty only). Flight surgeons (AFSC 48X3/4), normally the Aerospace Medicine Squadron/Flight Commander, or the senior squadron medical element (SME) flight surgeon (tenants only), as specifically identified by the parent MAJCOM, retain this authority. This authority will not be delegated further**.** At locations with flight surgeons who do not meet these criteria, the certification/waiver authority reverts to the MAJCOM of assignment. Non-flight surgeons are not authorized to sign, or certify medical examinations. Flight surgeons granted this authority by their MAJCOM may not certify/waiver ARC aircrew members. **Note**: Limited scope MTFs may delegate to a supporting MTF's Senior Aeromedical Specialist with MAJCOM approval and delegation.

15. Active duty non-aircrew members transitioning into ARC flying positions must have their medical examinations certified by the appropriate ARC Surgeon.

16. The final signature on SF 88 or DD Form 2808 in PEPP for Initial Flying Class I/IA/II//IIU/III and Special Operation Training examinations is the local SGP. The final review authority on all other examinations requiring this signature is the senior flight surgeon assigned.

17. State certification/waiver authority (ANG only). State Air Surgeons who are current, certified, and trained as specifically identified by NGB/SGPA retain this authority. This authority will not be delegated further. At locations where State Air Surgeons are not assigned, or are not trained, the certification/waiver authority reverts to NGB/SGPA.

18. Delegation of this certification authority is extended only to those Reserve Medical units responsible for providing physical exam support.

19. The appropriate ARC SG is the certification/waiver authority for AGR tour applicants with disqualifying **Chapter 5** medical conditions; disqualifying **Chapter 6**, **Section 6G** medical conditions; MAJCOM level tours; and AGR tours with no supporting ARC medical unit.

20. AETC/SGPS is the certification and waiver authority for all ARC members entering active duty in the regular Air Force. Before ARC members will be considered for waiver for active duty 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.

21. Verbal waivers are not 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.

Note: For example, if a local base flight surgeon requests an extension of sixty days to complete required tests, examinations, specialty consultations, etc., then the appropriate waiver authority may grant that waiver with an expiration date of sixty days in AIMWTS. The base level flight surgeon must then initiate a waiver renewal in AIMWTS.

22. MAJCOM certification and waiver authority:

Certification and waiver authority of medical standards may only be accomplished by a specialist in aerospace medicine. MAJCOM/SGs who are not RAMs will delegate their authority to an aerospace medicine specialist on their staff. When no RAM is assigned to the MAJCOM staff the waiver authority will be retained by AF/SG3PF unless delegated in writing by AF/SG3PF to a designated flight surgeon.

23. AETC/SGPS will retain waiver authority for UPT students from successful completion of an IFC physical and MFS, until they complete pilot training.

24. AETC/SG is the certification and waiver authority for individuals who do not meet standards and may delegate this authority to AETC/SGP and or SGPS. AF/SG3P retains waiver authority for those conditions it normally waives.

25. AFRC/SG is the authority for disqualifications.

26. AFRC/SG is waiver authority for all AD members entering the AF Reserve. Before AD members will be considered for waiver for the AF Reserve, all disqualifying defects must be appropriately evaluated for FFD per AFI 48-123, Chapter 5. Waiver by the AD authority does not guarantee waiver for AF Reserve duty.

Attachment 3

HEARING PROFILE

A3.1. H-1 Profile. The H-1 profile qualifies applicants for Flying Classes I and IA, initial Flying Class II and III, AF Academy, special operational duty, and selected career fields as noted in the Officer and Enlisted Classification Directories.

A3.1.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz:	500	1000	2000	3000	4000	6000
dB:	25	25	25	35	45	45

A3.2. H-2 Profile. The H-2 profile qualifies for AF enlistment, commission, initial Space and Missile Operations duty, and continued special operational duty, but requires evaluation for continued flying (See **6.44.4**).

A3.2.1. Definition: Unaided hearing loss in either ear with no single value greater than:

Hz:	500	1000	2000	3000	4000	6000
dB:	35	35	35	45	55	---

A3.3. H-3 Profile. The H-3 profile is disqualifying for enlistment, and civilian commission. It requires evaluation and MAJCOM waiver for continued flying, and Audiology evaluation for fitness for continued active duty. Aircrew with H-3 who change aircraft require an in-cockpit evaluation prior to waiver consideration.

A3.3.1. Definition: An H-3 profile is any loss that exceeds the values noted above in the definition of an H-2 profile.

A3.4. H-4 Profile. These require evaluation for continued service via either ARC Fitness for Duty (FFD), Worldwide Duty (WWD) processing, or review by the DAWG IAW AFI 10-203 for RTD, ALC Fast Track, or MEB.

A3.4.1. Definition: 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.

Notes: All personnel working in hazardous noise areas will be enrolled in the Hearing Conservation Program. The Air Force Hearing Conservation Program directive (found in AFOSH 48-20, *Occupational Noise and Hearing Conservation Program* must be consulted. Standard threshold shifts must be appropriately recorded and addressed whenever a significant shift in measured hearing threshold is noted. Such a shift may not result in a profile change. Exceeding the definition/standard for H-1 or H-2 automatically places the individual in the next highest category.