

S/S 1 July 1987

CHANGE
No. 35

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 9 February 1987

MEDICAL SERVICES

posted
27 March 87
OH

STANDARDS OF MEDICAL FITNESS

Effective 9 March 1987

This change incorporates policy changes, changes in standards of medical fitness and other administrative and professional refinements. It consolidates information previously published as interim changes.

Internal Control Systems. This regulation is not subject to the requirements of AR 11-2. It does not contain internal control provisions.

Interim changes are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

AR 40-501, 5 December 1960, is changed as follows:

1. New or changed material is indicated by a star.
2. Remove old pages and insert new pages as indicated below:

<i>Remove</i>	<i>Insert</i>
Cover 1 and title page (cover 2)	Cover 1 and title page (cover 2)
i through iv	i through iii
2-1 through 2-19	2-1 through 2-24
3-4.1 and 3-4.2, 3-5 through 3-10.1, and 3-11 through 3-16	3-4.1 through 3-17
4-3 through 4-8	4-3 through 4-8
4-15 through 4-18	4-15 through 4-18
5-1 through 5-5	5-1
6-5 and 6-6	6-5 and 6-6
6-13 and 6-14	6-13 and 6-14
7-1 through 7-12	7-1 through 7-11
8-1 through 8-5	8-1
9-1 through 9-4	9-1 through 9-4
9-7 through 9-12	9-7 through 9-12
10-7 through 10-14	10-7 through 10-13
10-17 through 10-26	10-17 through 10-26
11-5 and 11-6	11-5 and 11-6
11-9 through 11-11	11-9 and 11-10
A2-1	A2-1
A7-1	A7-1 and A7-2
A3-1 and A8-2	A8-1 and A8-2
A9-1 through A9-9	A9-1 through A9-9

3. File this change sheet in front of the publication for reference purposes.

*This change supersedes Interim Change 101, 14 March 1985, Interim Change 102, 1 November 1985, and Interim Change 103, 15 April 1986.

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General, United States Army
Chief of Staff

R. L. DILWORTH
Brigadier General, United States Army
The Adjutant General

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AR 40-501
*C 34

CHANGE }
No. 34 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 1 December 1983

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Effective 1 January 1984

This change incorporates policy changes, changes in standards of medical fitness and other administrative and professional refinements. It consolidates information previously published as interim changes.

Interim changes are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

This publication does not contain information that affects the New Manning System.

AR 40-501, 5 December 1960, is changed as follows:

1. New or changed material is indicated by a star.
2. Remove old pages and insert new pages as indicated below:

<i>Remove</i>	<i>Insert</i>
Cover 1 and title page (cover 2)	Cover 1 and title page (cover 2)
i through iv	i through iv
2-1 through 2-19	2-1 through 2-19
3-3 (C 32 page) through 3-4.1	3-4.1 and 3-4.2
3-9 through 3-10.1	3-9 through 3-10.1
3-13 through 3-16	3-13 through 3-16
4-1 through 4-11	4-1 through 4-20
5-1 through 5-6	5-1 through 5-5
6-1 through 6-4	6-1 through 6-4
6-7 and 6-8	6-7 and 6-8
6-11 through 6-14	6-11 through 6-14
7-1 through 7-10	7-1 through 7-12
8-1 through 8-5	8-1 through 8-5
9-1 through 9-11	9-1 through 9-12
10-1 through 10-18	10-1 through 10-31
A2-1	A2-1
A3-1 through A3-4	A3-1 and A3-2
A5-1	A5-1
A8-1 and A8-2	A8-1 and A8-2
A9-1 through A9-8	A9-1 through A9-9
Index-1 through Index-27	Index-1 through Index-31

*Posted
30 Nov 83*

3. File this change sheet in the front of the publication for reference purposes.

*This change supersedes Interim Change 106, 8 March 1983.

CHAPTER 7

MEDICAL FITNESS STANDARDS FOR MISCELLANEOUS PURPOSES

(Short Title: MISCELLANEOUS MEDICAL FITNESS STANDARDS)

Section I. GENERAL

7-1. Scope

This chapter sets forth medical conditions and physical defects which are causes for rejection for—

- a. Airborne training and duty, Ranger training and duty, and Special Forces training and duty.
- b. Army service schools.
- c. Diving training and duty.

- d. Enlisted military occupational specialties.
- e. Geographical area assignments.
- f. Service academies other than the US Military Academy.

7-2. Applicability

These standards apply to all applicants or individuals under consideration for selection or retention in these programs, assignments, or duties.

Section II. MEDICAL FITNESS STANDARDS FOR AIRBORNE TRAINING AND DUTY, FREE FALL PARACHUTE TRAINING AND DUTY, RANGER TRAINING AND DUTY, AND SPECIAL FORCES TRAINING AND DUTY

★7-3. Medical Fitness Standards for Initial Selection for Airborne Training, Ranger Training, and Special Forces Training

The causes of medical unfitness for initial selection for Airborne training, Ranger training, and Special Forces training are all the causes listed in chapter 2, plus all the causes listed in this section. Entrance into the Special Forces Qualification Course requires disposition of medical reports as described in chapter 10, paragraph 10-29c.

- a. *Abdomen and gastrointestinal system.*
 - (1) Paragraph 2-3.
 - (2) Hernia of any variety.
 - (3) Operation for relief of intestinal adhesions at any time.
 - (4) Laparotomy within a 6-month period.
 - (5) Chronic or recurrent gastrointestinal disorder.
- b. *Blood and blood-forming tissue diseases.*
 - (1) Paragraph 2-4.
 - (2) Sickle cell disease.
 - (3) For Special Forces, sickle cell trait until evaluated by Cdr, USAAMC, and found to have no increased susceptibility to the hazards and potential risks of the Special Forces environment.

c. *Dental.* Paragraph 2-5.

d. *Ears and hearing.*

- (1) Paragraphs 2-6 and 2-7.
- (2) Radical mastoidectomy.
- (3) Any infectious process of the ear until completely healed.
- (4) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of the eustachian tube.
- (5) Recurrent or persistent tinnitus.
- (6) History of attacks of vertigo, with or without nausea, emesis, deafness, or tinnitus.

e. *Endocrine and metabolic diseases.* Paragraph 2-8.

f. *Extremities.*

- (1) Paragraphs 2-9, 2-10, and 2-11.
- (2) Less than full strength and range of motion of all joints.
- (3) Loss of any digit from either hand.
- (4) Deformity or pain from an old fracture.
- (5) Instability of any degree of major joints.
- (6) Poor grasping power in either hand.
- (7) Locking of a knee joint at any time.
- (8) Pain in a weight bearing joint.

g. *Eyes and vision.*

- (1) Paragraphs 2-12 and 2-13 with exceptions noted below.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) direct to HQDA (DASG-PSP-O) WASH, DC 20310.

By Order of the Secretary of the Army:

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Major General, United States Army
The Adjutant General

JOHN A. WICKHAM, JR.
General, United States Army
Chief of Staff

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CHANGE }
No. 33 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC 1 September 1983

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Effective 1 October 1983

This change broadens the duty deployability requirements which must be considered when decisions are made as to fitness for duty.

Interim changes are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

This publication does not contain information that affects the New Manning System.

AR 40-501, 5 December 1960, is changed as follows:

1. New or changed material is indicated by a star.
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<i>Remove</i>	<i>Insert</i>
3-1 and 3-2 ✓	3-1 and 3-2 3-2-1

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AR 40-501
Aug 80

COPY 2

CHANGE

No. 32

AR 40-501

*C 32

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC 15 August 1980

MEDICAL SERVICES

STANDARDS OF MEDICAL FITNESS

Effective 15 September 1980

This change incorporates policy changes, changes in standards of medical fitness and other administrative and professional refinements.

Interim changes are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

AR 40-501, 5 December 1960, is changed as follows:

1. New or changed material is indicated by a star.
2. Remove old pages and insert new pages as indicated below:

Remove	Insert
✓ i through iv	✓ i through iv
✓ 2-1 and 2-2	✓ 2-1 and 2-2
✓ 2-3 through 2-6	✓ 2-3 through 2-6
✓ 2-17 through 2-19	✓ 2-17 through 2-19
✓ 3-1 through 3-4	✓ 3-1 through 3-4
✓ 3-13 and 3-14	✓ 3-13 and 3-14
✓ 4-1 through 4-12	✓ 4-1 through 4-11
✓ 5-3 and 5-4	✓ 5-3 and 5-4
✓ 7-1 through 7-9	✓ 7-1 through 7-10
✓ 9-1 through 9-10	✓ 9-1 through 9-11
✓ 10-1 through 10-22	✓ 10-1 through 10-18
✓ 11-3 through 11-6	✓ 11-3 through 11-6
✓ A2-1 and A2-2	✓ A2-1
✓ A3-3	✓ A3-3 and A3-4
✓ A7-1	✓ A7-1
✓ A8-1 and A8-2	✓ A8-1 and A8-2
✓ A9-1 through A9-9	✓ A9-1 through A9-8
None	✓ A10-1
Index-7 and Index-8	✓ Index-7 and Index-8
Index-11 and Index-12	✓ Index-11 and Index-12
Index-25 and Index-26	✓ Index-25 and Index-26

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*This change supersedes Interim Change I01, 21 August 1979.

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CHANGE

No. 31

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 27 May 1976

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Effective 1 July 1976

This change incorporates policy changes, changes in standards of medical fitness and other administrative and professional refinements.

AR 40-501, 5 December 1960, is changed as follows:

1. Changed material is indicated by a star.
2. Remove old pages and insert revised pages as indicated below:

<i>Remove pages</i>	<i>Insert pages</i>
2-1 and 2-2	2-1 and 2-2
2-11 and 2-12	2-11 and 2-12
3-1 through 3-4	3-1 through 3-4.1
3-7 through 3-10.1	3-7 through 3-10.1
3-13 and 3-14	3-13 and 3-14
4-1 through 4-6	4-1 through 4-6.1
4-9 through 4-12	4-9 through 4-12
5-1 through 5-5	5-1 through 5-6
7-7 and 7-8	7-7 and 7-8
8-1 and 8-2	8-1 through 8-2.01
8-5	8-5
9-1 through 9-12	9-1 through 9-10
10-1 through 10-4	10-1 through 10-4.1
10-7 through 10-16	10-7 through 10-16
10-17 through 10-18	10-21 and 10-22 (Fold-in)
11-3 through 11-6	11-3 through 11-6
A2-1 and A2-2	A2-1 and A2-2
A3-1 and A3-2	A3-1 and A3-2
A9-3 and A9-4	A9-3 and A9-4
A9-7 and A9-8	A9-7 and A9-8

3. File this change sheet in front of the publication for reference purposes.

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27 May 1976

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RESCINDED Per DA Circular 310-92

10 Jan 77

AR 40-501
C 30

Change
No. 30

Only

HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, DC, 27 August 1975

MEDICAL SERVICES

STANDARDS OF MEDICAL FITNESS

Effective 27 September 1975

This change implements the Privacy Act of 1974 (5 U.S.C. 552a) by adding Privacy Act Statements for forms prescribed in this publication that are covered under the act.

AR 40-501, 5 December 1960, is changed as follows:

- The following form(s) (colm b) will be reproduced locally on 8 x 10½ inch paper and made available on and after 27 September 1975 to the individual supplying data on form(s) in column a.

Column a	Column b
DA Form 3081-R -----	DA Form 3081-R, Privacy Act Statement
DA Form 3082 -----	DA Form 3082-R, Privacy Act Statement
DA Form 3083-R -----	DA Form 3083-R, Privacy Act Statement
DA Form 3349 -----	DA Form 3349-R, Privacy Act Statement
DA Form 4186 -----	DA Form 4186-R, Privacy Act Statement

- File this change sheet in front of the publication for reference purposes.

The proponent agency of this publication is the *Office of The Surgeon General.*
 (Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) direct to (DASG-HCH-O) WASH DC 20310.

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CHANGE }
No. 29 }HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 29 January 1974MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Effective 15 March 1974

This change incorporates policy changes on physical disability separations and retirements, administrative changes necessitated by the DA reorganization, changes in the drug and alcohol abuse standards for procurement as directed by DOD, and other administrative and professional refinements.

AR 40-501, 5 December 1960, is changed as follows:

1. Changed material is indicated by a star.
2. Remove old pages and insert revised pages as indicated below:

Remove pages ✓	Insert pages ✓
i through iv -----	i through iv -----
2-1 through 2-2.1 -----	2-1 through 2-2.1 -----
2-5 through 2-12 -----	2-5 through 2-12 -----
2-15 and 2-16 -----	2-15 through 2-16.1 -----
3-1 through 3-2.1 -----	3-1 through 3-2.1 -----
3-9 and 3-10 -----	3-9 through 3-10.1 -----
3-14.1 through 3-15 -----	3-15 and 3-16 -----
4-1 through 4-10 -----	4-1 through 4-12 -----
5-1 and 5-2 -----	5-1 through 5-2.01 -----
7-3 through 7-8.1 -----	7-3 through 7-9 -----
8-1 and 8-2 -----	8-1 through 8-2.1 -----
8-4.1 and 8-5 -----	8-5 -----
9-7 and 9-8 -----	9-7 and 9-8 -----
10-3 and 10-4 -----	10-3 and 10-4 -----
10-9 through 10-23 -----	10-9 through 10-19 -----
A9-5 and A9-6 -----	A9-5 and A9-6 -----

3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) direct to HQDA (DASG-HCH-O) Washington, DC 20314.

* This change supersedes DA messages DASG-HEP 081938Z Dec 72 (U), subject: Correction of Printing Errors in AR 40-501; DAPE-MPE 27 Feb 73 (U), subject: Change to AR 40-501; DASG-HCH 071909Z Jun 73 (U), subject: Changes to AR 40-501, Standards of Medical Fitness; DASG-HCH 041143Z Sep 73 (U), subject: Changes to Chapter 2, AR 40-501, Procurement Medical Fitness Standards.

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CHANGE

No. 28

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 14 June 1972

MEDICAL SERVICES

STANDARDS OF MEDICAL FITNESS

Effective 10 February 1972, in accordance with DA message
DASG-HES-Y 101955Z Feb 72

This change revises the administrative criteria for enlistment, appointment, or induction of individuals undergoing orthodontic treatment.

AR 40-501, 5 December 1960, is changed as follows:

1. Changed material is indicated by a star.
2. Remove old pages and insert revised pages as indicated below:

7-5 and 7-8 Remove pages Insert pages
7-5 and 7-8

3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) direct to HQDA (DASG-HES-Y) Washington, DC 20314.

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*This change supersedes DA message DASG-HES-Y 101955Z Feb 72 (U), Subject: Interim Change to AR 40-501 (Change 28) Orthodontic Appliances.

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CHANGE }
No. 27 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 10 August 1971

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Effective 15 October 1971

This change incorporates administrative and professional refinements to the various chapters and appendixes. The Departments of the Navy and Air Force have approved the entire change, although only certain chapters and appendixes are applicable to those services. The index has been completely revised.

AR 40-501, 5 December 1960, is changed as follows:

1. Paragraphs which are changed are indicated by a star.

2. Remove old pages and insert revised pages as indicated below:

<i>Remove pages--</i>	<i>Insert pages--</i>
2-3 through 2-8	2-3 through 2-8
2-13 through 2-19	2-13 through 2-19
3-1 through 3-2.1	3-1 through 3-2.1
3-5 through 3-8.1	3-5 through 3-8.1
4-3 through 4-6.1	4-3 through 4-6.1
5-1 and 5-2	5-1 through 5-2.1
6-3 through 6-6	6-3 through 6-6.1
7-1 through 7-2.1	7-1 through 7-2.1
7-4.1	7-4.1
7-7 and 7-8	7-7 through 7-8.1
8-1 through 8-4	8-1 through 8-4.1
9-1 through 9-10	9-1 through 9-12
10-1 through 10-20	10-1 through 10-18
A1-1 and A1-2	A1-1 and A1-2
A4-1 and A4-2	A4-1
A9-1 and A9-2	A9-1 through A9-2.1
A9-5 through A9-8	A9-5 through A9-9
I-1 through I-30	Index-1 through Index-36

3. File this change sheet in front of the publication for reference purposes.

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*This change supercedes DA message MEDPS-5X 101606Z Aug 71 (U), subject: Interim Change to AR 40-501.

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The Adjutant General.

W. C. WESTMORELAND,
General, United States Army,
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Distribution:

Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9 requirements for AR, Medical Service—Applicable to all Army Elements—A (Qty rqr block No. 104).

CHANGE
No. 26

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 12 January 1971

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Effective 30 November 1970 in accordance with DA message MEDPS-SX
302140Z Nov 70

This change reflects the current opinion of the authorities in the field of tuberculosis. It has been approved by the Departments of the Navy and the Air Force and the Department of Defense.

AR 40-501, 5 Dec 1960, is changed as follows:

1. Paragraphs which are changed are indicated by a star.
2. Remove old pages and insert revised pages as indicated below:

Remove pages—	Insert pages—
2-13 and 2-14.....	2-13 and 2-14
8-3 and 8-4.....	8-3 and 8-4

3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) to The Surgeon General, ATTN: MEDPS, Department of the Army, Washington, DC 20314.

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Distribution:

Active Army, ARNG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for AR, Medical Service—Applicable to all Army Elements—A (qty rqr block No. 104).

*This change supersedes DA message MEDPS-SX 302140Z Nov 70 (U), subject: Interim Change to AR 40-401 (Change 26) Standards of Medical Fitness.

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CHANGE |
No. 25 |

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 2 February 1970

**MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS**

This change is published to correct printer's errors in Change 24, 10 November 1969.

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended is indicated by a star.
2. Remove old pages and insert corrected pages as follows:

<i>Remove pages—</i>	<i>Insert pages—</i>
✓ 2-11 through 2-14	2-11 through 2-14
✓ 2-17 through 2-18.1	2-17 through 2-18
3-3 and 3-4	3-3 and 3-4

3. File this change sheet in front of the publication for reference purposes.

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CHANGE }
No. 24 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 10 November 1969

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Effective 1 January 1970

This change incorporates administrative and professional refinements to the various chapters and appendixes. The Departments of the Navy and Air Force have approved the entire change, although only certain chapters and appendixes are applicable to those services. Attention is invited to the fact that DA message 897173, 12 February 1969, pertaining to changes to retention medical fitness standards, is rescinded by this change. Appendix II is completely revised to provide both American Standards Association, and International Standard Organization audiometric hearing levels and a conversion table.

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended or added is indicated by a star.
2. Remove old pages and insert new pages as indicated below:

<i>Remove pages—</i>	<i>Insert pages—</i>
i through iii	i through iv
2-1 and 2-2 ✓	2-1 through 2-2.01
2-9 through 2-14 ✓	2-9 through 2-14
2-17 and 2-18 ✓	2-17 through 2-18.1 ✓
3-1 and 3-2 ✓	3-1 through 3-2.01 ✓
3-3 through 3-8 ✓	3-3 through 3-8.1 ✓
3-11 through 3-14 ✓	3-11 through 3-14.1 ✓
4-3 through 4-6	4-3 through 4-6.01
5-3 and 5-4	5-3 and 5-4
6-9 and 6-10 ✓	6-9 and 6-10 ✓
6-12.1 through 6-14 ✓	6-12.1 through 6-14 ✓
7-1 and 7-2	7-1 through 7-2.01
7-3 and 7-4	7-3 and 7-4
7-7 and 7-8 ✓	7-7 and 7-8
9-7	9-7
10-7 and 10-8 ✓	10-7 and 10-8
A2-1	A2-1 through A2-3
A3-3 ✓	A3-3
A9-5 and A9-6 ✓	A9-5 through A9-6.1

3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications) to The Surgeon General, ATTN: MEDPS, Department of the Army, Washington, DC 20314.

For sale by the Superintendent of Documents

*This change supersedes DA message 897173, 12 February 1969



By Order of the Secretary of the Army:

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Official:

KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Service—Applicable to all Army Elements—A (Quan Rqr Block No. 104).

CHANGE }
No. ~~43~~ }
23

HEADQUARTERS
DEPARTMENT OF THE ARMY.
WASHINGTON, D.C., 4 February 1969

MEDICAL SERVICES STANDARDS OF MEDICAL FITNESS

AR 40-501, 5 December 1960, is changed as follows:

1. Paragraph which has been changed is indicated by a star.
- ✓ 2. Remove page 3-15 and insert revised page 3-15.
3. File this change sheet in front of the publication for reference purposes.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements to The Surgeon General, ATTN: MEDPS, Department of the Army, Washington, D.C. 20315.

By Order of the Secretary of the Army:

Official:

KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

W. C. WESTMORELAND,
General, United States Army,
Chief of Staff.

Distribution:

Active Army, ARNG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for AR, Medical Service—Applicable to All Army Elements—A. (quantity block No. 104).

*This change supersedes so much of DA message 890080, 10 December 1968, as pertains to AR 40-501.

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 19 June 1968

CHANGE }
No. 22 }

MEDICAL SERVICE STANDARDS OF MEDICAL FITNESS

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended or added is indicated by a star.
2. The following pen-and-ink changes will be made:
 - a. Page 3-3, paragraph 3-4c, line 2. Delete so much as reads: "(to be published)."
 - b. Page 11-4, paragraph 11-8(5), line 4. Delete so much as reads: "Tonometry will be performed only by physicians."
 - c. Change all references to DA Form 8-274 to read: "DA Form 3349".
3. Remove old pages and insert new pages as indicated below:

Remove pages	Insert pages
1-1 through 1-3	1-1 through 1-3
2-1 and 2-2	2-1, 2-2, and 2-2.1
2-9 through 2-12	2-9 through 2-12
2-17 and 2-18	2-17 and 2-18
3-1 and 3-2	3-1, 3-2, and 3-2.1
4-7 and 4-8	4-7 and 4-8
5-3 and 5-4	5-3 and 5-4
6-7 and 6-8	6-7 and 6-8
7-1 and 7-2	7-1, 7-2, and 7-2.1
7-5 through 7-7	7-5 through 7-8
8-1 through 8-5	8-1 through 8-5
9-1 and 9-2	9-1 and 9-2
9-5, 9-6, and 9-6.1	9-5, 9-6, and 9-6.1
9-9 and 9-10	9-9 and 9-10
A1-1 and A1-2	A1-1 through A1-2
A3-1 and A3-2	A3-1 through A3-2
A8-1 and A8-2	A8-1 and A8-2
A9-5 and A9-6	A9-5 and A9-6

4. This transmittal sheet should be filed in front of the publication for reference purposes.

This change supersedes DA message 850024, 31 January 1968.

The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements to The Surgeon General, ATTN: MEDPS, Department of the Army, Washington, D.C. 20315.

By Order of the Secretary of the Army:

Official:

KENNETH G. WICKHAM,
*Major General, United States Army,
The Adjutant General.*

HAROLD K. JOHNSON,
*General, United States Army,
Chief of Staff.*

Distribution:

Active Army, NG and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Service—A.

CHANGE }
No. 21 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 10 July 1967

MEDICAL SERVICE

STANDARDS OF MEDICAL FITNESS

AR 40-501, 5 December 1960, is changed as follows:

- 1. Material which has been added is indicated by a star.
- 2. Remove page 2-19 and insert revised page 2-19.
- 3. This transmittal sheet should be filed in front of the publication for reference purposes.

[MEDAO-P]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:

KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Service—A.

CHANGE }
No. 20 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 28 April 1967

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended or rescinded is indicated by a star.
2. Remove old pages and insert new pages as indicated below:

Remove pages	Insert pages
7-1 and 7-2.....	7-1 and 7-2.
7-7.....	7-7.
10-5 and 10-6.....	10-5 and 10-6.
10-9 and 10-10.....	10-9 and 10-10.

3. This transmittal sheet should be filed in front of the publication for reference purposes.

[OTSG]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:

KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for medical service—A.

CHANGE }
No. 19 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 12 April 1967.

MEDICAL SERVICE

STANDARDS OF MEDICAL FITNESS

AR 40-501, 5 December 1960, is changed as follows:

- 1. Material which has been amended or added is indicated by a bold star.
- 2. Remove old pages and insert new pages as indicated below:

Remove pages--	Insert pages--
iii ----- -----	iii 11-1 through 11-11 ✓

3. This transmittal sheet should be filed in front of the publication for reference purposes.

(MEDPS-SX)

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:

KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Service—A.

CHANGE }
No. 18

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 4 April 1967

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

AR 40-501, 5 December 1960, is changed as follows:

- ✓ 1. Material which has been amended is indicated by a star.
- ✓ 2. Remove pages 3-1 through 3-16 and insert revised pages 3-1 through 3-15.
- ✓ 3. This transmittal sheet should be filed in front of the publication for reference purposes.

[MEDPS-SX]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
*General, United States Army,
Chief of Staff.*

Official:

KENNETH G. WICKHAM,
*Major General, United States Army,
The Adjutant General.*

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Services—A.

cl. 20000 4

CHANGE }
No. 17 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 17, October 1966

MEDICAL SERVICE

STANDARDS OF MEDICAL FITNESS

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended is indicated by a star.
2. Remove old pages and insert new pages as indicated below:

Remove pages—	Insert pages—
2-1 and 2-2.....	2-1 and 2-2 ✓
3-1 and 3-2.....	3-1 and 3-2 ✓
10-15 and 10-16.....	10-15 and 10-16 ✓

3. This transmittal sheet should be filed in front of the publication for reference purposes.

[MEDPS-SX]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
*General, United States Army,
Chief of Staff.*

Official:

KENNETH G. WICKHAM,
*Major General, United States Army,
The Adjutant General.*

Distribution:

Active Army, NG and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Service—A.

*This change supersedes DA message 753524, 4 March 1966; and DA message 772611, 6 July 1966.

CHANGE }
 No. 16 }

HEADQUARTERS
 DEPARTMENT OF THE ARMY
 WASHINGTON, D.C., 12 August 1966

MEDICAL SERVICE

STANDARDS OF MEDICAL FITNESS

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended or added is indicated by a star.
2. Remove pages 3-7 and 3-8 and insert revised pages 3-7 and 3-8.
3. This transmittal sheet should be filed in front of the publication for reference purposes.

[MEDPS-SX]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:

KENNETH G. WICKHAM,
Major General, United States Army,
The Adjutant General.

Distribution:

To be distributed in accordance with DA Form 12-9 requirements for Medical Service:

Active Army: A. NG: A. USAR: A.

*This change supersedes DA message 758615, 5 April 1966.

CHANGE }
No. 15 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 11 March 1966

MEDICAL SERVICE

STANDARDS OF MEDICAL FITNESS

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended or added is indicated by a bold-faced star.
2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
iii	iii
1-1 and 1-2	1-1 through 1-3
2-5, 2-6, 2-6.1 and 2-7 through 2-17	2-5 and 2-6, 2-7 through 2-19
3-3 and 3-4	3-3 and 3-4
3-9 through 3-12	3-9 through 3-12.1
3-15 and 3-16	3-15 and 3-16
4-1 and 4-2	4-1, 4-2, and 4-2.1
5-3 and 5-4	5-3 and 5-4
6-5 and 6-6	6-5 and 6-6
6-9 through 6-12	6-9 through 6-12.1
7-5 and 7-6	7-5 and 7-6
8-3 through 8-5	8-3 through 8-5
9-5 and 9-6	9-5 and 9-6.1
	10-1 through 10-23
A3-1 and A3-2	A3-1 and A3-2
A9-1	A9-1 through A9-8

3. This transmittal sheet should be filed in front of the publication for reference purposes.

[MEDPS-SX]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Service—A.

CHANGE
No. 14

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 18 January 1965

**MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS**

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended or added is indicated by a star.
2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
✓ 2-1 through 2-6	2-1 through 2-6.1 ✓
✓ 2-9 and 2-10	2-9 and 2-10 ✓
✓ 3-1 and 3-2	3-1 and 3-2 ✓
✓ 4-1 through 4-6	4-1 through 4-6.1 ✓
✓ 5-3 and 5-4	5-3 and 5-4

3. This transmittal sheet should be filed in front of the publication for reference purposes.

[MEDAS]

By Order of the Secretary of the Army:

HAROLD K. JOHNSON,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Service—A.

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

CHANGE }
No. 13 }

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 13 May 1964

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended or added is indicated by a bold type star.
2. Remove old pages and insert new pages as indicated below.

✓ Remove pages—	✓ Insert pages—
2-1, 2-2.....	2-1, 2-2
2-5 through 2-8.....	2-5 through 2-8
2-13, 2-14.....	2-13, 2-14
4-1 through 4-4.....	4-1 through 4-4
7-1, 7-2.....	7-1, 7-2
7-5, 7-6.....	7-5, 7-6, 7-6.1
8-3 through 8-5.....	8-3 through 8-5
9-5 through 9-7.....	9-5 through 9-7
A9-1 and A9-2.....	A9-1
I-17, I-18.....	I-17, I-18

3. This transmittal sheet should be filed in front of the publication for reference purposes.

[MEDAS]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations for Medical Services—A.

*This change supersedes DA message 936767, 16 September 1963, and DA message 941444, 18 October 1963.

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

CHANGE }
No. 12 }

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 11 October 1963

AR 40-501, 5 December 1960, is changed as follows:

Page 3-10, paragraph 3-21g(2). Paragraph 3-21g(2) "Chronic serious pericarditis" is changed to read "Chronic serous pericarditis".

(MEDAS)

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

CHANGES }
No. 11 }

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON, D.C., 30 August 1963

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended is indicated by a bold type star.
2. Remove old pages and insert new pages as indicated below.

<input checked="" type="checkbox"/> Remove pages—	<input checked="" type="checkbox"/> Insert pages—
<input checked="" type="checkbox"/> 3-1 through 3-17.....	3-1 through 3-16
7-5, 7-6, and 7-7.....	7-5, 7-6, and 7-7

[MEDAS]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:
J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:
Active Army, NG, and USAR: To be distributed in accordance with DA
Form 12-9 requirements for Medical Service—A.

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

CHANGES }
No. 7 }

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., 17 May 1963

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been amended or added is indicated by a bold type star.
2. Remove old pages and insert new pages as indicated below.

Remove pages—	Insert pages—
2-3, 2-4.....	2-3, 2-4.
2-7, 2-8.....	2-7, 2-8.
2-13 through 2-16.....	2-13 through 2-16.
4-1 through 4-6.....	4-1 through 4-6.
5-3, 5-4.....	5-3, 5-4.
6-1, 6-2.....	6-1 through 6-14.
8-3, 8-4.....	8-3, 8-4.
AI-1, AI-2.....	AI-1, AI-2.
I-1 through I-32.....	I-1 through I-30.

[MEDAS]

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for Medical Services—A.

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

CHANGES }
No. 9 }

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., 11 February 1963

AR 40-501, 5 December 1960, is changed as follows:

Remove pages 7-1, 7-2, and 7-5 through 7-7 and insert revised pages 7-1, 7-2, and 7-5 through 7-7.

(MEDPS)

By Order of the Secretary of the Army:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

CHANGES }
No. 8 }

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., 2 October 1962

AR 40-501, 5 December 1960, is changed as follows:

Appendix IX is added by these changes.

[AG 702 (5 Sep 62) MEDAS]

BY ORDER OF THE SECRETARY OF THE ARMY:

EARLE G. WHEELER,
General, United States Army,
Chief of Staff.

Official:

J.C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, NG, and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

*These changes supersede paragraph 2d, AR 40-500, 16 August 1956, including so much of C 6, 10 December 1958, as pertains to paragraph 2d.

COPY 1

MEDICAL SERVICE STANDARDS OF MEDICAL FITNESS

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., 10 September 1962

CHANGES

No. 7

AR 40-501, 5 December 1960, is changed as follows:

1. Paragraphs which have been amended or added are indicated by a bold type star.
2. Remove old pages and insert new pages as indicated below.

Remove pages--	Insert pages--
2-3 through 2-14.....	2-3 through 2-14
2-17.....	2-17.....
3-11 and 3-12.....	3-11 and 3-12
3-15 and 3-16.....	3-15 and 3-16
4-3 and 4-4.....	4-3 and 4-4
4-7 and 4-8.....	4-7 and 4-8
7-1 through 7-4.....	7-1 through 7-4. 1
8-1 and 8-2.....	8-1 and 8-2
I-1 through I-4.....	I-1 through I-4
I-7 and I-8.....	I-7 and I-8
I-15 and I-16.....	I-15 and I-16
I-23 and I-24.....	I-23 and I-24
I-27 and I-28.....	I-27 and I-28

[AG 702 (3 Aug. 62) MEDPS]

BY ORDER OF THE SECRETARY OF THE ARMY:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations--Medical Service--B.

NG: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations--Medical Service--A.

*These changes supersede DA message 583847, 13 December 1961.

**MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS**

HEADQUARTERS;
DEPARTMENT OF THE ARMY
WASHINGTON 25, D. C., 16 March 1962

CHANGES
No. 6

VAR 40-501, 5 December 1960, is changed as follows:

1. Paragraphs which have been amended are indicated by a bold type star.
2. Remove old pages and insert new pages as indicated below.

Remove pages--	Insert pages--
2-7 through 2-10.....	2-7 through 2-10
2-13 and 2-14.....	2-13, and 2-14
3-1 through 3-4.....	3-1 through 3-4
3-7 through 3-12.....	3-7 through 3-12, and 3-12.1
5-1 and 5-2.....	5-1 and 5-2
8-3 and 8-4.....	8-3 and 8-4
9-9 and 9-10.....	9-9 and 9-10
I-1 and I-2.....	I-1 and I-2
I-9 through I-16.....	I-9 through I-16
I-21 through I-24.....	I-21 through I-24
I-29 through I-32.....	I-29 through I-32

[AG 702 (15 Feb 62) MEDPS]

BY ORDER OF THE SECRETARY OF THE ARMY:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

- Active Army and USAR:* To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—B.
- NG:* To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

Copy

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS
Effective 1 April 1962

CHANGES
No. 5

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., 20 February 1962

AR 40-501, 5 December 1960, is changed as follows:

1. Material which has been added or changed is indicated by a bold type star.
2. Remove old pages and insert new pages as indicated below.

Remove pages	Insert pages
iii	iii
1-1 and 1-2	1-1 and 1-2
	9-1 through 9-10
	A8-1 and A8-2

[AG 702 (5 Oct 61) MEDPS]

BY ORDER OF THE SECRETARY OF THE ARMY:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army and USAR: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—B.

NG: To be distributed in accordance with DA Form 12-9 requirements for DA Regulations—Medical Service—A.

*These changes supersede section II, and paragraphs 24a and 25, AR 40-503, 9 May 1956, including C 1, 3 August 1956, and C 3, 6 May 1959. (AR 40-503 is now superseded in its entirety.)

C.1

Sept 2

AR 40-501
*C 4

MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

CHANGES }
No. 4 }

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., 23 October 1961

AR 40-501, 5 December 1960, is changed as follows:

1. Paragraphs which have been added or amended are indicated by a bold type star.
2. Remove old pages and insert new pages as indicated below:

<i>Remove pages</i>	<i>Insert pages</i>
2-7	2-7
2-8	2-8

[AG 702 (29 Sep 61) MEDPS]

BY ORDER OF THE SECRETARY OF THE ARMY:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

J. C. LAMBERT,
Major General, United States Army,
The Adjutant General.

Distribution:

- Active Army and USAR:* To be distributed in accordance with DA Form 12-4 requirements for DA Regulations—Medical Service—B.
- NG:* To be distributed in accordance with DA Form 12-4 requirements for DA Regulations—Medical Service—A.

*These changes rescind DA message 575238, 2 October 1961.

MEDICAL SERVICE

STANDARDS OF MEDICAL FITNESS

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., 29 August 1961

CHANGES
No. 3

AR 40-501, 5 December 1960, is changed as follows:

1. Chapters, sections, or paragraphs which have been added or amended are indicated by a bold type star.
2. Remove old pages and insert new pages as indicated below:

Remove pages—	Insert pages—
2-11, 2-12.....	2-11, 2-12
7-7, 7-8.....	7-7
A3-1, A3-2.....	A3-1, A3-2

BY ORDER OF THE SECRETARY OF THE ARMY:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

R. V. LEE,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, USAR: To be distributed in accordance with DA Form 12-4 requirements for DA Regulations—Medical Services—B.

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MEDICAL SERVICE
STANDARDS OF MEDICAL FITNESS

CHANGES }
No. 2 }

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., 24 March 1961

AR 40-501, 5 December 1960, is changed as follows:

So much of the supersession note of C 1, 10 February 1961, as reads "sections I, III, and IV, paragraphs 19 through 23 and 24b, and sections VII through XXIII, AR 40-503, including C 3, 6 May 1959, and so much of C 1, 3 August 1956" is changed to read "sections I, III, and IV, paragraphs 19 through 23 and 24b, and sections VII through XXIII, AR 40-503, 9 May 1956, including so much of C 1, 3 August 1956, and C 3, 6 May 1959, as pertains to these paragraphs and sections."

[AG 702 (23 Mar 61) MEDPS]

BY ORDER OF THE SECRETARY OF THE ARMY:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

R. V. LEE,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army and USAR: To be distributed in accordance with DA Form 12-4 requirements for DA Regulations—Medical Services—B.

NG: To be distributed in accordance with DA Form 12-4 requirements for DA Regulations—Medical Services—A.

MEDICAL SERVICE

STANDARDS OF MEDICAL FITNESS

Effective 1 April 1961

CHANGES

No. 1

HEADQUARTERS,
DEPARTMENT OF THE ARMY
WASHINGTON 25, D.C., 10 February 1961

AR 40-501, 5 December 1960, is changed as follows:

1. Chapters, sections, paragraphs which have been added or amended are indicated by a bold type star.
2. Remove old pages and insert new pages as indicated below:

Remove pages--	Insert pages--
i.....	vi through iii
I-1.....	1-1 and 1-2
2-1.....	2-1 through 2-17
3-1 and 3-2.....	3-1 and 3-2
4-1.....	4-1 through 4-10
5-1.....	5-1 through 5-5
6-1.....	6-1 and 6-2
7-1.....	7-1 through 7-7
A1-1.....	A1-1 and A1-2
A2-1.....	A2-1
A3-1.....	A3-1 and A3-2
A5-1.....	A5-1
A6-1.....	A6-1
	I-1 through I-32

[AG 702 (9 Jan 61) MEDPS]

BY ORDER OF THE SECRETARY OF THE ARMY:

Official:

R. V. LEE,
Major General, United States Army,
The Adjutant General.

G. H. DECKER,
General, United States Army,
Chief of Staff.

Distribution:

Active Army and USAR: To be distributed in accordance with DA Form 12-4 requirements for DA Regulations—Medical Services—B.

AG: To be distributed in accordance with DA Form 12-4 requirements for DA Regulations—Medical Services—A.

*These changes supersede AR 40-110, 12 November 1952, including C 6, 4 September 1959; paragraphs 1, 3 through 8, 13 through 19, and 21, AR 40-500, 16 August 1956, including C 8, 6 April 1960, and so much of C 3, 26 August 1957, C 6, 10 December 1958, and C 7, 6 October 1959, as pertains to these paragraphs; sections I, III, and IV, paragraphs 19 through 23 and 24b, and sections VII through XXIII, AR 40-503, including C 3, 6 May 1959, and so much of C 1, 3 August 1956; medical fitness standards contained in paragraph 4b, AR 611-22, 10 April 1959; and paragraph 15f(1), AR 612-35, 31 July 1958.

C 35, AR 40-501
AR 40-501

ARMY REGULATION

Change 1-35,

S/S 19 July 1987

**MEDICAL SERVICES
STANDARDS OF
MEDICAL FITNESS**

Multiple copies of this regulation are available from the Army Medical Department Center and School, Fort Sam Houston, Texas 78243-5000. For more information, contact the Director of the Center and School, (714) 542-1000.

HEADQUARTERS, DEPARTMENT OF THE ARMY

DECEMBER 1960

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON 25, DC, 5 December 1960

AR 40-501, Medical Service—Standards of Medical Fitness, is published for the use of all concerned. Chapters 3 and 8 are effective 15 January 1961.

[AG 702 (10 Nov 60) MEDPS]

By Order of *Wilber M. Brucker*, Secretary of the Army:

G. H. DECKER,
General, United States Army,
Chief of Staff.

Official:

R. V. LEE,
Major General, United States Army,
The Adjutant General.

Distribution:

Active Army, USAR: To be distributed in accordance with DA Form 12-4 requirements for DA Regulations—Medical Service—B.
NG: To be distributed in accordance with DA Form 12-4 Requirements for DA Regulations—Medical Service—A.

★ The proponent agency of this regulation is the Office of the Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) direct to HQDA (SGPS-CP-B), 5111 Leesburg Pike, Falls Church, VA 22041-3258.

This regulation also supersedes AR 40-500, 16 August 1956, including C 3, 26 August 1957, C 6, 10 December 1958, C 7, 6 October 1959, C 9, 8 February 1961, C 10, 30 August 1961; DA messages 575238, 2 October 1961, 583847, 13 December 1961, 936767, 16 September 1963, 941444, 18 October 1963, 958578, 6 March 1964, 986290, 15 September 1964, 758615, 5 April 1966, 753524, 4 March 1966, 772611, 6 July 1966, 850024, 31 January 1968, so much of DA message 890080, 10 December 1968 as pertains to AR 40-501; and DA message 897173, 12 February 1969.

C 26 supersedes DA message MEDPS—SX 302040Z Nov 70 (U), subject: Interim Change to AR 40-501 (Change 26) Standards of Medical Fitness.

*These regulations supersede AR 40-504, 28 June 1955, including C 1, 6 February 1959; DA letter AGAC-C (M) 220.01 (31 Dec 52) MEDCA, 12 January 1953, subject: Physical Standards for Special Registrants under Public Law 779; OTSG letter MEDDP, 23 March 1953, subject: Physical Standards for Special Registrants under Public Law 779; OTSG letter, MEDDP, 1 May 1953, subject: Physical Standards for Special Registrants under Public Law 779; DA message 402203, 9 April 1959; DA message 409220, 9 May 1959; and DA message 435843, 11 September 1959; AR 40-110, 12 November 1952, including C 6, 4 September 1959; medical fitness standards contained in paragraph 4b, AR 611-22, 10 April 1959; paragraph 15f(1), AR 612-35, 31 July 1958; and AR 40-503, 9 May 1956, including C 1, 3 August 1956, and C 3, 6 May 1959.

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CHAPTER 1

GENERAL PROVISIONS

The provisions of this chapter apply to all individuals evaluated under the provisions of any other chapter contained in this regulation.

Section I. INTRODUCTION

1-1. Purpose

This regulation provides medical fitness standards of sufficient detail to insure uniformity in the medical evaluation of—

a. Candidates for military service or persons in the military service in terms of medical conditions and physical defects which are causes for rejection or medical unfitness for military service.

b. Candidates for, and persons in, certain enlisted military occupational specialties and officer duty assignments, in terms of medical conditions and physical defects which are causes for rejection or medical unfitness for these specialized duties.

1-2. Objectives

The objectives of this regulation are as follows:

a. Chapter 2. Commission and enlist in the Active Army and its reserve components, enroll in the Advanced Course Army ROTC, and induct, under peacetime conditions, individuals who are—

- (1) Free of contagious or infectious diseases which would be likely to endanger the health of other personnel.
- (2) Free of medical conditions or physical defects which would require excessive time lost from duty by reason of necessary treatment or hospitalization or most probably result in separation from the service by reason of medical unfitness.
- (3) Medically capable of satisfactorily completing required training.

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

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

b. Chapter 3. Provide for the timely separation from the Active Army and its reserve components, of those individuals whose continued performance of duty would compromise their health and well-being or prejudice the interests of the Government.

c. Chapter 4. Provide realistic procurement and retention standards for the Army Aviation Program.

d. Chapter 5. Accept as cadets for the U.S. Military Academy only those individuals who are medically capable of undergoing the rigorous training program at the academy and who can reasonably be expected to qualify for appointment in the Regular Army upon graduation.

e. Chapter 6. Effect the maximum utilization of manpower under conditions of mobilization by procuring individuals who can be expected to be productive in the military establishment.

f. Chapter 7. Provide realistic procurement and retention medical fitness criteria for miscellaneous officer and enlisted duty assignments while excluding from consideration for such duties individuals with medical conditions or physical defects which would compromise their health and well-being or prejudice the interests of the Government.

g. Chapter 8. Effect the maximum utilization of physicians and dentists evaluated under the Universal Military Training and Service Act as amended by procuring physicians and dentists who, although they may have physical defects or medical conditions which would ordinarily be cause for rejection for original entry into the military service, may be expected to perform appropriate military duties as physicians and dentists.

h. Chapter 9. Provide a physical profile serial system which characterizes, primarily according to functional capabilities, all Army personnel throughout their military service, and all other persons examined under the provisions of chapter 2 for potential procure-

ment into the Armed Forces, which system will assist in the classification and assignment distribution of military personnel and in the collection of statistics relevant to medical fitness standards.

★*i. Chapter 10.* Provide general administrative guidance for the conduct of military medical examinations; and specific policy statements regarding the scope of these examinations, manner of recording findings, their frequency and validity periods of the examination.

★*j. Chapter 11.* Provide detailed instructions for the performance of military medical examination.

Section II. CLASSIFICATION

1-3. Medical Classification

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

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

b. Medically Unacceptable. Medical examiners will report as "medically unacceptable" by reason of medical unfitness all individuals who possess any one or more of the medical conditions or physical defects listed in this regulation as a cause of rejection for the specific purpose for which examined, except as noted in *c* below. Examinees reported as medically unacceptable by reason of medical unfitness

when the medical fitness standards in chapters 2, 3, 6 or 8 apply will be given a physical profile. Examinees found medically unacceptable when the medical fitness standards in chapters 4, 5, or 7 apply will not be given a physical profile. Individuals found to be medically unacceptable for military service will not be reported as permanently medically unfit for military service except upon the finding of Headquarters, Department of the Army, or of a medical or physical evaluation board.

c. Medically Unacceptable—Prior Administrative Waiver Granted. Medical examiners will report as "medically unacceptable—prior administrative waiver granted" all individuals who do not meet the medical fitness standards established for the particular purpose for which examined when a waiver has been previously granted and all of the provisions of paragraph 1-4c apply. Such individuals will be given a physical profile.

Section III. WAIVERS

1-4. Waivers

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

b. Examinees initially reported as medically unacceptable by reason of medical unfitness

when the medical fitness standards in chapters 2, 3, 4, 5, 6, 7, or 8 apply, may request a waiver of the medical fitness standards in accordance with the basic administrative directive governing the personnel action. Upon such request, the designated administrative author-

ity or his designee for the purpose may grant such a waiver in accordance with current directives.

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

(1) Duration of the waiver was not limited at the time it was granted, and

(2) Medical condition or physical defect has not interfered with the individual's successful performance of military duty, and

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

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

***CHAPTER 2**
PHYSICAL STANDARDS FOR ENLISTMENT, APPOINTMENT,
AND INDUCTION

Section I. GENERAL

2-1. Purpose

This chapter implements Department of Defense (DOD) Directive 6130.3 "Physical Standards for Enlistment, Appointment, and Induction," March 31, 1986, which established physical standards for enlistment, appointment, and induction into the Armed Forces of the United States in accordance with section 133, title 10, United States Code (10 USC 133). The MEDICAL STANDARDS PORTIONS of the following references were superseded by DOD Directive 6130.3:

a. DOD Instruction 1205.1, "Implementation of the Universal Military Training and Service Act With Respect to Medical and Dental Registrants," September 27, 1960.

b. DOD Directive 1145.1, "Qualitative Distribution of Military Manpower," January 22, 1986.

c. DOD Directive 1215.14, "Armed Forces Health Professions Scholarship Program," February 4, 1975.

2-2. Applicability and Responsibilities

a. Applicability.

(1) This chapter sets forth the medical conditions and physical defects which are causes for rejection for military service, including the service/admissions formerly covered in chapters 5 and 8 of this regulation. Those individuals found medically qualified based on the medical standards in effect prior to change 35 of this regulation will not be reevaluated or medically disqualified solely on the basis of the new standards. Other standards may be prescribed in the event of mobilization or a national emergency.

(2) The standards of chapter 2 apply to—

(a) Applicants for appointment as commissioned or warrant officers in the Regular Army, the Army of the United States (AUS), or in the Reserve components of the Army, including the United States Army Reserve and the Army National Guard of the United States.

(b) Applicants for enlistment in the Regular Army. For medical conditions or physical defects predating original enlistment, these standards are applicable for enlistees' first 6 months of active duty. (However, for members of the Army National Guard or Army Reserve who apply for enlistment in the Regular Army or who re-enter active duty for training under the "split-training" option, the standards of chapter 3 are applicable.)

(c) Applicants for enlistment in the Army Reserve and Federally recognized units or organizations of the Army National Guard. For medical conditions or physical defects predating original enlistment, these standards are applicable during the enlistees' initial period of active duty for training until their return to Reserve Component units.

(d) Applicants for reenlistment in the Regular Army, Army Reserve Components, and Federally recognized units or organizations of the Army National Guard after a period of more than 6 months has elapsed since discharge.

(e) Applicants for the United States Military Academy, Scholarship or Advanced Course Army Reserve Officers' Training Corps (ROTC), Uniformed Services University of the Health Sciences, and all other Army special officer procurement programs; e.g., Officer Candidate School.

(f) Cadets at the United States Military Academy and in Army ROTC programs, except for such conditions that have been diagnosed since entrance into an academy or ROTC program. With respect to such conditions, upon recommendation of the Surgeon, United States Military Academy (USMA) (for USMA cadets), or the Surgeon, United States Army Training and Doctrine Command (for ROTC cadets), the medical fitness standards of chapter 3 are applicable for retention in the Academy, the ROTC program, appointment or enlistment, and entrance on active duty or active duty for training in a commis-

sioned or enlisted status. However, the standard in paragraph 2-39m applies to USMA and ROTC cadets whether chapter 2 or 3 standards of this regulation are applicable.

(g) All individuals being inducted into the Army.

b. Responsibilities.

(1) The Assistant Secretary of Defense for Health Affairs (ASD(HA)) will review, approve, and issue technical modifications to the standards set forth in DOD Directive 6130.3.

(2) The secretary of the Army will—

(a) Revise Army policies to conform with the standards contained in DOD Directive 6130.3.

(b) Recommend to the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) suggested changes in the

standards after Service coordination has been accomplished.

(c) Review all the standards on a quadrennial basis and recommended changes to the OASD(HA). This review will be initiated and coordinated by the DOD Medical Examination Review Board.

(d) Have authority to grant a waiver of the standards in individual cases for appropriate reasons, unless waiver authority has been withheld by the Secretary of Defense; for example, HTLV-III.

(e) Have authority to establish other standards for special programs.

(f) Have authority to issue Army-specific exceptions to these standards, having first submitted these, with justification, for review and approval by the ASD(HA).

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

2-3. Abdominal Organs and Gastrointestinal System

The causes for rejection for appointment, enlistment, and induction are—

a. Esophagus. Organic disease or authenticated history of, such as ulceration, varices, achalasia, or other dysmotility disorders; chronic or recurrent esophagitis if confirmed by appropriate X-ray or endoscopic examinations.

b. Stomach and duodenum.

(1) Gastritis, chronic hypertrophic, severe.

(2) Ulcer of the stomach or duodenum, if diagnosis is confirmed by X-ray examinations, endoscopy, or authenticated history thereof.

(3) Authenticated history of surgical operation(s) for gastric or duodenal ulcer; i.e., partial or total gastric resection, gastrojejunostomy, pyloroplasty, truncal or selective vagotomy (or history of such operative procedures for any other cause or diagnosis).

(4) Duodenal diverticula with symptoms or sequelae (hemorrhage, perforation, etc.).

(5) Congenital abnormalities of the stomach or duodenum causing symptoms or requiring surgical treatment.

(6) History of surgical correction of hy-

pertrophic pyloric stenosis of infancy is not disqualifying if currently asymptomatic.

c. Small and large intestine.

(1) Intestinal obstruction or authenticated history of more than one episode if either occurred during the preceding 5 years or if resulting condition remains, producing significant symptoms or requiring treatment.

(2) Symptomatic Meckel's diverticulum.

(3) Megacolon of more than minimal degree.

(4) Inflammatory lesions: Diverticulitis, regional enteritis, ulcerative colitis, or proctitis.

(5) Intestinal resection; however, minimal intestinal resection in infancy or childhood (for example, for intussusception) is acceptable if the individual has been asymptomatic since the resection and if the appropriate consultant finds no residual impairment.

(6) Malabsorption syndromes.

d. Gastrointestinal bleeding, history of, unless the cause has been corrected.

e. Hepato-pancreatico-biliary tract:

(1) Hepatitis within the preceding 6 months; or persistence of symptoms after 6 months, with objective evidence of impaired liver function.

(2) Hepatic cysts—congenital cystic dis-

ease; parasitic, protozoal, or other cysts.

(3) Cirrhosis, regardless of the absence of manifestations such as jaundice, ascites, or known esophageal varices; abnormal liver function, with or without history of chronic alcoholism.

(4) Cholecystectomy, sequelae of, such as postoperative stricture of the common bile duct, re-forming of stones in hepatic or common bile ducts, incisional hernia, or postcholecystectomy syndrome when symptoms are so severe as to interfere with normal performance of duty.

(5) Cholecystitis, acute or chronic, with or without cholelithiasis, if diagnosis is confirmed by usual laboratory procedures or medical records.

(6) Bile duct abnormalities or strictures.

(7) Pancreas, acute or chronic disease of, if proven by laboratory tests or medical records; and congenital anomalies such as annular pancreas, cystic disease, etc.

f. Anorectal.

(1) Fistula in ano.

(2) Incontinence.

(3) Anorectal stricture.

(4) Excessive mucous production with soiling.

(5) Hemorrhoids—when large, symptomatic, or history of bleeding—internal or external.

(6) Rectal prolapse.

(7) Symptomatic rectocele.

(8) Symptomatic anal fissure.

(9) Chronic diarrhea, regardless of cause.

g. Spleen.

(1) Splenomegaly until the cause is corrected.

(2) Splenectomy, except when accomplished for the following:

(a) Trauma.

(b) Causes unrelated to diseases of the spleen.

(c) Hereditary spherocytosis.

(d) Disease involving the spleen when followed by correction of the condition for at least 2 years.

h. Tumors. See paragraph 2-41.

i. Abdominal wall.

(1) Scars.

(a) Scars, abdominal, regardless of cause, the hernial bulging of which interferes with movement.

(b) Scar pain associated with disturbance of function of abdominal wall or contained viscera.

(c) Sinuses of the abdominal wall, to include persistent urachus and persistent omphalomesenteric duct.

(2) Hernia.

(a) Hernia other than small asymptomatic umbilical or asymptomatic hiatal.

(b) History of operation for hernia within the preceding 60 days.

j. Other. Congenital or acquired abnormalities, such as gastrointestinal bypass or stomach stapling for control of obesity; and defects that preclude satisfactory performance of military duty or require frequent and prolonged treatment.

Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

2-4. Blood and Blood-Forming Tissue Diseases

The causes for rejection for appointment, enlistment, and induction are—

a. Anemia.

(1) Blood loss anemia—until both the condition and basic cause are corrected.

(2) Deficiency anemia, uncontrolled by medication. Pernicious anemia even if controlled by B12 injections.

(3) Abnormal destruction of RBCs: Hemolytic anemia, to include enzyme deficiencies, with evidence of ongoing hemolysis;

microangiopathic and any other hemolytic anemia, acquired or inherited.

(4) Faulty RBC construction and miscellaneous anemias including hemoglobinopathies, sideroblastic anemias, thalassemia major, and sickle-cell disease. Heterozygous conditions such as G6PD deficiency, thalassemia minor and sickle-cell trait may be acceptable if the hemoglobin is within the examining laboratory's normal limits, Hgb S is less than Hgb A and there is no history or evidence or crisis, decreased exercise tolerance or other complications.

(5) Myelophthisic anemias from any cause.

(6) Macroglobulinemia.

(7) Primary refractory anemias: aplastic anemia, paroxysmal nocturnal hemoglobinuria, and pure red-cell aplasia.

b. Hemorrhagic states.

(1) Due to inherited or acquired abnormalities in the coagulation system.

(2) Due to quantitative or qualitative platelet deficiency.

(3) Due to vascular instability (e.g., hereditary hemorrhagic telangiectasia).

c. Leukopenia, chronic or recurrent, associated with increased susceptibility to infection.

d. Myeloproliferative disease.

(1) Myelofibrosis/myeloid metaplasia.

(2) Primary thrombocythemia.

(3) Polycythemia rubra vera.

(4) Di Guglielmo's syndrome.

(5) Chronic granulocytic leukemia (see sec XX below).

e. Splenomegaly until the cause is remedied.

f. Thromboembolic disease except for acute, nonrecurrent thrombophlebitis.

g. Immunodeficiency diseases (see also para 2-39m).

h. Miscellaneous conditions, such as porphyria, hemochromatosis, amyloidosis, and post-splenectomy status (except when secondary to causes stated in para 2-3g).

Section IV. DENTAL

2-5. Dental

The causes of rejection for appointment, enlistment, and induction are—

a. Diseases of the jaw or associated tissues which are not easily remediable, and will incapacitate the individual or otherwise prevent the satisfactory performance of duty.

b. Severe malocclusion which interferes with normal mastication or requires early and protracted treatment; or relationship between mandible and maxilla that precludes satisfactory future prosthodontic replacement.

c. Insufficient natural healthy teeth or lack of a serviceable prosthesis, preventing adequate mastication and incision of a normal diet.

d. Orthodontic appliances for continued treatment, attached or removable. Retainer appliances are permissible, provided all orthodontic treatment has been satisfactorily completed. Individuals undergoing orthodontic care are acceptable for enlistment in the Delayed Entry Program or a Reserve Component of the Army only if a civilian or military orthodontist provides documentation that active orthodontic treatment will have been completed prior to entry on initial active duty for training or active duty. Individuals with retainer orthodontic appliances who are not required to undergo further active treatment are administratively acceptable for appointment, enlistment, induction, initial active duty for training, or active duty status.

Section V. EARS AND HEARING

2-6. Ears

The causes for rejection for appointment, enlistment, and induction are—

a. Auditory canal.

(1) Atresia or severe stenosis of the external auditory canal.

(2) Tumors of the external auditory canal except mild exostoses.

(3) Severe external otitis, acute or chronic.

b. Auricle. Microtia, severe; or severe traumatic deformity, unilateral or bilateral.

c. Mastoids.

(1) Mastoiditis, acute or chronic.

(2) Residual of mastoid operation with marked external deformity which precludes or interferes with the wearing of a protective mask or helmet.

(3) Mastoid fistula.

d. Meniere's Syndrome.

e. Middle ear.

(1) Acute or chronic suppurative otitis media.

(2) Adhesive otitis media associated with hearing level by audiometric test of 30 dB or more average for the speech frequencies (500, 1000, and 2000 Hertz) in either ear regardless of the hearing level in the other ear.

(3) Acute or chronic serous otitis media.

(4) Presence of attic perforation in which presence of cholesteatoma is suspected.

(5) Repeated attacks of catarrhal otitis media; intact greyish, thickened drum(s).

(6) History of surgery involving the middle ear, excluding myringotomy.

(7) Cholesteatoma.

f. Tympanic membrane.

(1) Any perforation of the tympanic membrane.

(2) Surgery to repair perforated tympanic membrane within the past 120 days.

(3) Severe scarring of the tympanic membrane associated with hearing level by audiometric test of 30 dB or more average for

the speech frequencies (500, 1000, and 2000 Hertz) in either ear regardless of the hearing level in the other ear.

g. Other diseases and defects of the ear which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

2-7. Hearing (see also para 2-6)

The cause for rejection for appointment, enlistment, and induction is a *hearing threshold level* greater than that described in table 2-1. (As an exception to guidelines in appendix VIII and for administrative purposes only, personnel examined at the Military Entrance Processing stations for initial entrance into Active or Reserve Component Army service, who are disqualified because of failure to meet the hearing standards described in table 2-1, will be given the numerical designator "3E" under the "H" factor of the physical profile. Personnel evaluated under chap 3 will be profiled in accordance with app VIII.)

Table 2-1. Acceptable Audiometric Hearing Levels

Audiometers, calibrated to the International Standards Organization (ISO 1964) or the American National Standards Institute (ANSI 1969), will be used to test the hearing of all applicants for appointment, enlistment, or induction.

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

Acceptable Audiometric Hearing Level for Appointment,
Enlistment, and Induction
ISO 1964—ANSI 1969
Both ears

Pure tone at 500, 1000, and 2000 cycles per second of not more than 30 dB on the average (either ear), with no individual level greater than 35 dB at these frequencies; and level not more than 45 dB at 3000 cycles per second each ear, and 55 dB at 4000 cycles per second each ear.

Section VI. ENDOCRINE AND METABOLIC DISORDERS

2-8. Endocrine and Metabolic Disorders

The cause for rejection for appointment, enlistment, and induction are—

a. Adrenal dysfunction of any degree.

b. Cretinism.

c. *Diabetes mellitus*, any type, or a history of diabetes mellitus in both natural parents. A history of Juvenile Onset (Insulin-dependent, Type I) is also disqualifying even if there

is no current need for insulin and blood sugars are normal.

d. *Gigantism or acromegaly*.

e. *Gout*.

f. *Hyperinsulinism, confirmed, symptomatic*.

g. *Hyperparathyroidism and hypoparathyroidism*.

h. *Hypopituitarism*.

i. Myxedema, spontaneous or postoperative (with clinical manifestations).

j. Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy).

k. Glycosuria, persistent. Individuals who present acceptable evidence that their glycosuria is not associated with impaired glucose tolerance or with renal tubular defects that cause aminoaciduria, phosphaturia, and renal tubular acidosis are acceptable.

l. Thyroid disorders.

(1) Goiter: simple goiter with definite pressure symptoms, or so large as to interfere with the wearing of a military uniform or military equipment.

(2) Hyperthyroidism or thyrotoxicosis.

(3) Hypothyroidism.

(4) Thyroiditis.

m. Other endocrine or metabolic disorders that obviously preclude satisfactory performance of duty, or require frequent or prolonged treatment.

Section VII. EXTREMITIES

2-9. Upper Extremities (see also para 2-11)

The cause for rejection for appointment, enlistment, and induction are—

a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement appear in TM 8-640/AFP 160-14.

(1) *Shoulder.*

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) *Elbow.*

(a) Flexion to 100 degrees.

(b) Extension to 15 degrees.

(3) *Wrist.* A total range to 60 degrees (extension plus flexion). Radial and ulnar deviation combined arch 30 degrees.

(4) *Hand.*

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) *Fingers.* Inability to clench fist, pick up a pin or needle, and grasp an object.

(6) *Thumb.* Inability to touch tips of at least 3 fingers.

b. Hand and fingers.

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

(2) Absence or loss of distal and middle phalanx of an index, middle, or ring finger of either hand regardless of the absence or loss of the little finger.

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

(4) Absence of a hand or any portion thereof except for fingers as noted above.

(5) Hyperdactylia.

(6) Scars and deformities of the fingers or hand which impair circulation, are symptomatic, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

(7) Intrinsic paralyses or weakness (either median or ulnar nerves) sufficient to produce physical findings in the hand (for example, muscle atrophy or weakness).

c. Wrist, forearm, elbow, arm, and shoulder. Recovery from disease or injury of wrist, elbow, or shoulder with residual weakness or symptoms such as to preclude satisfactory performance of duty. Grip strength of less than 75 percent of predicted normal when injured hand is compared with the normal hand (non-dominant is 80 percent of dominant grip).

2-10. Lower Extremities (see also para 2-11)

The causes for rejection for appointment, enlistment, and induction are—

a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement appear in TM 8-640/AFP 160-14.

(1) *Hip.*

(a) Flexion to 90 degrees (minimum).

(b) No demonstrable flexion contracture.

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

(d) Abduction to 45 degrees.

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

(2) *Knee.*

- (a) Full extension.
- (b) Flexion to 90 degrees.

(3) *Ankle.*

- (a) Dorsiflexion to 10 degrees.
- (b) Plantar flexion to 30 degrees.
- (c) Eversion and inversion (total to 5 degrees).

(4) *Toes.* Stiffness that interferes with walking, marching, running, or jumping.

b. Foot and ankle.

(1) Absence of one or more small toes if the function of the foot is poor or running or jumping is precluded; absence of a foot or any portion thereof except for toes as noted herein.

(2) Absence of great toe(s); loss of dorsal flexion thereof if the function of the foot is impaired.

(3) Claw toes precluding the wearing of appropriate military footwear.

(4) Clubfoot if there is any residual varus or equinus of the hind foot, degenerative changes in the mid or hind foot, or significant stiffness or deformity precludes foot function or the wearing of appropriate military footwear.

(5) Flatfoot, pronounced cases, with decided eversion of the foot and marked bulging of the inner border, due to inward rotation of the astragalus, regardless of the presence or absence of symptoms.

(6) Flatfoot, tarsal coalition.

(7) Hallux valgus, if severe and associated with marked extostosis or bunion.

(8) Hammer toe or hallux rigidus that interferes with the wearing of appropriate military footwear.

(9) Effects of disease, injury, or deformity including hyperdactylia that preclude running, are accompanied by disabling pain, or prohibit the wearing of appropriate military footwear.

(10) Ingrowing toe nails, if severe, and not remediable.

(11) Obliteration of the transverse arch associated with permanent flexion of the small toes.

(12) Overriding of any of the toes, if symptomatic or sufficient to interfere with the wearing of appropriate military footwear.

(13) Pes cavus, with contracted plantar fascia, dorsiflexed toes, tenderness under the metatarsal heads, and callosity under the weight bearing areas.

c. Leg, knee, thigh, and hip.

(1) Dislocated semilunar cartilage, loose or foreign bodies within the knee joint.

(2) Physical findings of an unstable or internally deranged joint.

(3) History of surgical correction of torn semilunar cartilage, loose or foreign bodies within the knee joint during the preceding 6 months. If 6 months or more (6 weeks or more for arthroscopic surgery) have elapsed since operation without recurrence, and any of the following are present: Instability of the knee ligaments in anteroposterior, medial, or lateral directions in comparison with a normal knee, significant abnormalities noted on X-ray, less than 80 percent strength (as measured by Cybex or similar devices) of the thigh musculature in comparison with the normal side, unacceptable active motion in flexion and extension, persistent effusion or other symptoms of internal derangement.

(4) History of surgical correction of knee ligaments during the past 12 months. If more than 12 months have elapsed since surgery without recurrence, if there is evidence of more than mild instability of the knee ligaments in medial, lateral, or anteroposterior directions in comparison with a normal knee, weakness or atrophy of the thigh musculature in comparison with the normal side; or if the individual requires bracing or medical treatment of sufficient frequency to interfere with the performance of military duty.

(5) Authenticated history of congenital dislocation of the hip, osteochondritis of the hip (Legg-Perthes disease), or slipped femoral epiphysis of the hip. These conditions are not disqualifying if there is no X-ray evidence of residual deformity or degenerative changes, or with any clinically significant limitation of motion.

(6) Authenticated history of hip dislocation within 2 years before examination or degenerative changes on the X-ray from the old hip dislocation.

(7) Osteochondritis of the tibial tuber-

osity (Osgood-Schlatter disease), if symptomatic or with obvious prominence of the part and X-ray evidence of a separated bone fragment.

d. General.

(1) Deformities of one or both lower extremities that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life or that would interfere with the satisfactory completion of prescribed training and performance of military duty.

(2) Diseases or deformities of the hip, knee, or ankle joint that interfere with walking, running, or weight bearing.

(3) Pain in the lower back or leg that is intractable and disabling to the degree of interfering with walking, running, and weight bearing.

(4) Shortening of a lower extremity resulting in a noticeable limp or scoliosis.

2-11. Miscellaneous (see also paras 2-9 and 2-10)

The causes for rejection for appointment, enlistment, and induction are—

a. Arthritis.

(1) Active, subactive, or chronic arthritis.

(2) Chronic osteoarthritis or traumatic arthritis of isolated joints of more than a minimal degree, which has interfered with the following of a physically active vocation in civilian life or which precludes the satisfactory performance of military duty.

(3) Documented clinical history of rheumatoid arthritis, including ankylosing spondylitis.

(4) Traumatic arthritis of a major joint of more than a minimal degree.

b. Chondromalacia, manifested by authenticated history of chronic pain, joint effusion, interference with function, residuals from surgery, or X-ray changes.

c. Disease of any bone or joint, healed, with such resulting deformity or rigidity that function is so impaired it will interfere with military service.

d. Dislocation, old, unreduced; substantiated history of recurrent dislocations of major joints; instability of a major joint, symptomatic and more than mild; or if, subsequent to surgery, there is no evidence of more than mild instability in comparison with the normal joint, weakness or atrophy in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

e. Fractures.

(1) Malunited fractures that interfere significantly with function.

(2) Ununited fractures.

(3) Any old or recent fracture in which a plate, pin, or screws used for fixation were left in place; for example, an anterior tibial plate.

f. Injury of a bone or joint of more than a minor nature, yet without fracture or dislocation, that occurred within the preceding 6 weeks.

g. Joint replacement.

h. Muscular paralysis, contracture, or atrophy, if progressive or of sufficient degree to interfere with military service.

i. Myotonia congenita. Confirmed.

j. Osteochondritis dessicans, if symptomatic.

k. Osteochondromatosis or multiple cartilaginous exostoses.

l. Osteomyelitis, active or recurrent; any bone or substantiated history of osteomyelitis of any of the long bones unless successfully treated 2 or more years previously without subsequent recurrent or disqualifying sequelae as demonstrated by both clinical and X-ray evidence.

m. Osteoporosis.

n. Scars, extensive, deep, or adherent to the skin and soft tissues or neuromas of an extremity that are painful, that interfere with muscular movements, that preclude the wearing of military clothing or equipment, or that show a tendency to break down.

Section VIII. EYES AND VISION

2-12. Eyes

The causes for rejection for appointment, enlistment, and induction are—

a. Lids.

(1) Blepharitis, chronic, of more than mild degree. Cases of acute blepharitis will be rejected until cured.

(2) Blepharospasm.

(3) Dacryocystitis, acute or chronic.

(4) Destruction of the lids, complete or extensive, sufficient to impair protection of the eye from exposure.

(5) Adhesions of the eyelids to each other or to the eyeball which interfere with vision.

(6) Growth or tumor of the eyelid other than small early basal cell tumors of the eyelid, which can be cured by treatment, and small nonprogressive asymptomatic benign lesions. (See also para 2-41.)

(7) Marked inversion or eversion of the eyelids sufficient to cause troublesome watering of eyes (entropion or ectropion).

(8) Lagophthalmos.

(9) Ptosis interfering with vision.

(10) Trichiasis, severe.

b. Conjunctiva.

(1) Conjunctivitis, chronic, including vernal catarrh and trachoma; acute conjunctivitis unless cured.

(2) Pterygium.

(a) Recurring after three operative procedures.

(b) Encroaching on the cornea in excess of 3 millimeters, interfering with vision, or is progressive (as evidenced by marked vascularity on a thickened elevated head).

(3) Xerophthalmia.

c. Cornea.

(1) Dystrophy, corneal, of any type, including keratoconus of any degree.

(2) History of keratorefractive surgery accomplished to modify the refractive power of the cornea, or of lamellar/penetrating keratoplasty.

(3) Keratitis, acute or chronic.

(4) Ulcer, corneal; history of recurrent ulcers or corneal abrasions (including herpetic ulcers).

(5) Vascularization or opacification of the cornea from any cause which is progressive or reduces vision below the standards prescribed in paragraph 2-13.

d. Uveal tract. Inflammation of the uveal tract except healed traumatic choroiditis.

e. Retina.

(1) Angiomatoses, phakomatoses, retinal cysts, and other congenito-hereditary conditions that impair visual functions.

(2) Chorioretinitis, unless a single episode which has healed and does not interfere with vision.

(3) Degenerations of the macula to include macular cysts, holes, and other degenerations (hereditary or acquired degenerative changes and other conditions affecting the macula, including all types of primary and secondary pigmentary degenerations).

(4) Detachment of the retina, history of surgery for same, or peripheral retinal injury or degeneration likely to cause retinal detachment.

(5) Inflammation of the retina (histoplasmosis, toxoplasmosis or vascular conditions of the retina to include Coats' disease, diabetic retinopathy, Eales' disease, and retinitis proliferans), unless a single episode which has healed and does not interfere with vision.

f. Optic nerve.

(1) Congenito-hereditary conditions of the optic nerve or any other central nervous system pathology affecting the efficient function of the optic nerve.

(2) Optic neuritis, neuroretinitis, or secondary optic atrophy resulting therefrom or documented history of attacks of retrobulbar neuritis.

(3) Optic atrophy (primary or secondary).

(4) Papilledema.

g. Lens.

(1) Aphakia (unilateral or bilateral), pseudophakia.

(2) Dislocation, partial or complete, of a lens.

(3) Opacities of the lens which interfere

with vision or which are considered to be progressive.

h. Ocular mobility and motility.

(1) Diplopia, documented, constant or intermittent from any cause or of any degree.

(2) Nystagmus, with both eyes fixing, congenital or acquired.

(3) Strabismus of 40 prism diopters or more, uncorrectable by lenses to less than 40 diopters.

(4) Strabismus of any degree accompanied by documented diplopia.

(5) Strabismus, surgery for the correction of, within the preceding 6 months.

(6) However, for entrance into the US Military Academy or Army ROTC Scholarship Programs, the following conditions are also disqualifying:

(a) Esotropia of over 15 prism diopters.

(b) Exotropia of over 10 prism diopters.

(c) Hypertropia of over 2 prism diopters.

i. Miscellaneous defects and diseases.

(1) Abnormal conditions of the eye or visual fields due to diseases of the central nervous system. Meridian specific visual field minimums are—

(a) Temporal: 85 degrees.

(b) Superior temporal: 55 degrees.

(c) Superior: 45 degrees.

(d) Superior nasal: 55 degrees.

(e) Nasal: 60 degrees.

(f) Inferior nasal: 50 degrees.

(g) Inferior: 65 degrees.

(h) Inferior temporal: 85 degrees.

(2) Absence of an eye.

(3) Asthenopia, severe.

(4) Exophthalmos, unilateral or bilateral, non-familial.

(5) Glaucoma, primary, or secondary, or pre-glaucoma as evidenced by intraocular pressure above 25 mmHg, or the secondary changes in the optic disc or visual field loss associated with glaucoma.

(6) Hemianopsia of any type.

(7) Loss of normal pupillary reflex reactions to light or accommodation to distance or Adie's syndrome.

(8) Loss of visual fields due to organic disease.

(9) Night blindness.

(10) Residuals of old contusions, lacerations, penetrations, etc., impairing visual function required for satisfactory performance of military duty.

(11) Retained intraocular foreign body.

(12) Tumors. (See paras 2-12a(6) and 2-41.)

(13) Any organic disease of the eye or adnexa not specified above, which threatens vision or visual function.

2-13. Vision

The causes of medical rejection for appointment, enlistment, and induction are listed below. Special administrative criteria for assignment to certain specialities will be separately published by the Army.

a. Distant visual acuity. Distant visual acuity of any degree which does not correct with spectacle lenses to at least one of the following:

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

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

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

(4) However, for entrance into the US Military Academy or Army ROTC Scholarship Programs, distant visual acuity which does not correct to 20/20 in each eye is disqualifying. For entrance into Officer Candidate School (OCS) the provisions of paragraph 7-19 are applicable.

b. Near visual acuity. Near visual acuity of any degree that does not correct to 20/40 in the better eye.

c. Refractive error. Any refractive error in spherical equivalent of over -8.00 or +8.00 diopters; or if ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement, etc.; if an ophthalmological consultation reveals a condition which is disqualifying; or if refractive error is corrected by orthokeratology or keratorefractive surgery. However, for entrance into the US Military Academy or Army ROTC Scholarship

Programs, the following conditions are disqualifying:

- (1) Anisometropia over 3.50 diopters.
- (2) Astigmatism, all types over 3 diopters.
- (3) Hyperopia over 5.50 diopters in any meridian.
- (4) Myopia over 5.50 diopters in any meridian.
- (5) Refractive error corrected by orthokeratology or keratorefractive surgery.

d. Contact lenses. Complicated cases requiring contact lenses for adequate correc-

tion of vision such as keratoconus, corneal scars, and irregular astigmatism.

e. Color vision. Although there is no standard, color vision will be tested, since adequate color vision is a prerequisite for entry into many military specialties. However, for entrance into the US Military Academy or Army ROTC Scholarship Programs, the inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or vivid green is disqualifying. For entrance into Officer Candidate School, the provisions of paragraph 7-19 are applicable.

Section IX. GENITOURINARY SYSTEM

2-14. Genitalia (see also para 2-41)

The causes for rejection for appointment, enlistment, and induction are—

- a. Bartholinitis*, Bartholin's cyst.
- b. Cervicitis*, acute or chronic, manifested by leukorrhea.
- c. Dysmenorrhea*, incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.
- d. Endometriosis*, or confirmed history thereof.
- e. Hermaphroditism.*
- f. Hydrocele or left varicocele*, if larger than the attendant testicle, painful, or any right varicocele unless urological evaluation reveals no disease.
- g. Menopausal syndrome*, physiologic or artificial if manifested by more than mild constitutional or mental symptoms, or artificial menopause if less than 13 months have elapsed since cessation of menses. In all cases of artificial menopause, the clinical diagnosis will be reported; if accomplished by surgery, the pathologic report will be obtained and recorded.
- h. Menstrual cycle*, irregularities of, including menorrhagia, if excessive; metrorrhagia; polymenorrhea; amenorrhea, except as noted in paragraph 2-14g.
- i. New growths of the internal or external genitalia*, except a single uterine fibroid, subserous, asymptomatic, less than three centimeters in diameter, with no general

enlargement of the uterus may be acceptable. (See also para 2-41.)

- j. Oophoritis*, acute or chronic.
- k. Ovarian cysts*, persistent, clinically significant.
- l. Pregnancy.*
- m. Salpingitis*, acute or chronic.
- n. Testicle(s).* (See also para 2-41.)
 - (1) Absence of both testicles.
 - (2) Undiagnosed enlargement or mass of testicle or epididymis.
 - (3) Undescended testicle(s).
- o. Urethritis*, acute or chronic, other than gonorrheal urethritis without complications.
- p. Uterus.*
 - (1) Cervical polyps, cervical ulcer, or marked erosion.
 - (2) Endocervicitis, more than mild.
 - (3) Generalized enlargement of the uterus due to any cause.
 - (4) Malposition of the uterus if more than mildly symptomatic.
 - (5) Pap smears graded Class 2, 3, or 4, (Class 2 smears are acceptable if the diagnosis is benign), or any smear in which the descriptive terms dysplasia, carcinoma-in-situ, or invasive cancer are used.
- q. Vagina.*
 - (1) Congenital abnormalities or severe lacerations of the vagina.
 - (2) Vaginitis, acute or chronic, manifested by leukorrhea.
- r. Vulva.*
 - (1) Leukoplakia.

(2) Vulvitis, acute or chronic.

s. Major abnormalities and defects of the genitalia, such as a change of sex, a history thereof, or dysfunctional residuals from surgical correction of these conditions.

2-15. Urinary System (see paras 2-8 and 2-41)

The causes for rejection for appointment, enlistment, and induction are—

a. *Cystitis, chronic*. Individuals with acute cystitis are unacceptable until the condition is cured.

b. *Enuresis* determined to be a symptom of an organic defect not amenable to treatment. (See also para 2-33c.)

c. *Epispadias or hypospadias* when accompanied by evidence of infection of the urinary tract, or if clothing is soiled when voiding.

d. *Hematuria, cylinduria, pyuria*, or other findings indicative of renal tract disease.

e. *Incontinence* of urine.

f. *Kidney*.

(1) Absence of one kidney, regardless of cause.

(2) Acute or chronic infections of the kidney.

(3) Cystic or polycystic kidney, confirmed history of.

(4) Horseshoe kidney.

(5) Hydronephrosis or pyonephrosis.

(6) Nephritis, acute or chronic.

(7) Pyelitis, pyelonephritis.

g. *Orchitis*, chronic, or chronic epididymitis.

h. *Penis*, amputation of, if the resulting stump is insufficient to permit micturition in a normal manner.

i. *Peyronie's disease*.

j. *Prostate gland*, hypertrophy of, with urinary retention; chronic prostatitis.

k. *Proteinuria* under normal activity (at least 48 hours after strenuous exercise) greater than 200 mg/24 hours.

l. *Renal calculus*.

(1) Substantiated history of bilateral renal calculus at any time.

(2) Verified history of renal calculus at any time with evidence of stone formation within the preceding 12 months, current symptoms, or positive X-ray for calculus.

m. *Skenitis*.

n. *Urethra*. Stricture of the urethra.

o. *Urinary fistula*.

p. *Other diseases and defects of the urinary system* that obviously preclude satisfactory performance of duty or require frequent and prolonged treatment.

Section X. HEAD AND NECK

2-16. Head

The causes for rejection for appointment, enlistment, and induction are—

a. *Abnormalities* that are apparently temporary in character resulting from recent injuries until a period of 3 months has elapsed. These include severe contusions and other wounds of the scalp and cerebral concussion. (See para 2-29.)

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

c. *Deformities of the skull* in the nature of depressions, exostoses, etc., of a degree which would prevent the individual from wearing a protective mask or military headgear.

d. *Deformities of the skull* of any degree associated with evidence of disease of the brain, spinal cord, or peripheral nerves.

2-12

e. *Depressed fractures* that required surgical elevation or were associated with a laceration of the dura mater or focal necrosis of the brain. (See para 2-29.)

f. *Loss or congenital absence* of the bony substance of the skull not successfully corrected by reconstructive materials.

g. *All cases involving absence of the bony substance of the skull* that have been corrected but in which the defect is in excess of 1 square inch (6.45 cm²) or the size of a 25-cent piece.

2-17. Neck

The causes for rejection for appointment, enlistment, and induction are—

a. *Cervical ribs* if symptomatic, or so obvious that they are found on routine physical examination. (Detection based primarily on

X-rays is not considered to meet the criterion.)

b. *Congenital cysts* of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.

c. *Fistula*, chronic draining, or any type.

d. *Nonspastic contraction* of the muscles of

the neck or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment or is so disfiguring as to make the individual objectionable in common social relationships.

e. *Spastic contraction* of the muscles of the neck, persistent, and chronic.

f. *Tumor of thyroid or other structures of the neck.* (See para 2-41.)

Section XI. HEART AND VASCULAR SYSTEM

2-18. Heart

The causes for rejection for appointment, enlistment, and induction are—

a. *All valvular heart diseases* including those improved by surgery except mitral valve prolapse and bicuspid aortic valve. These latter two conditions are not reasons for rejection unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.

b. *Coronary heart disease.*

c. *History of symptomatic arrhythmia* or electrocardiographic evidence of arrhythmia.

(1) Supraventricular tachycardia, atrial flutter, atrial fibrillation, ventricular tachycardia or fibrillation. Premature atrial or ventricular contractions are disqualifying when sufficiently symptomatic to require treatment or result in physical or psychological impairment. Multifocal premature ventricular contractions are disqualifying irrespective of symptoms or treatment. Supraventricular tachycardia, atrial flutter, and atrial fibrillation are not disqualifying if there has been no recurrence during the preceding 2 years off all medication.

(2) Left bundle branch block, Mobitz type II second degree AV block and third degree AV block. Conduction disturbances such as first degree AV block, left anterior hemiblock, right bundle branch block or Mobitz type I second degree AV block are not disqualifying when asymptomatic and are not associated with underlying cardiovascular disease. Accelerated AV conduction (Wolfe-Parkinson-White syndrome) and Lown-Ganong-Levine syndrome are not disqualifying unless associated with an arrhythmia.

d. *Hypertrophy or dilatation of the heart* as evidenced by chest X-ray, electrocardiogram, or echocardiogram. Cardiomyopathy, myocarditis, or history of congestive heart failure from any cause even though currently compensated. Care must be taken to avoid rejection of highly conditioned individuals with sinus bradycardia, increased cardiac volume, and apparent abnormal cardiac enlargement, as indicated by EKG and X-ray.

e. *Pericarditis* except in individuals who have been free of symptoms for 2 years and manifest no evidence of cardiac restriction or persistent pericardial effusion.

f. *Persistent tachycardia* (resting pulse rate of 100 or greater), regardless of cause.

g. *Congenital anomalies* of heart and great vessels with physiologic or actuarial significance, which have not been totally corrected.

2-19. Vascular System

The cause for rejection for appointment, enlistment, and induction are—

a. *Abnormalities* of the arteries and blood vessels, aneurysms, atherosclerosis, arteritis.

b. *Hypertension* evidenced by a preponderance of diastolic blood pressure over 90 mmHg or preponderance of systolic blood pressure over 159 mmHg at any age; high blood pressure requiring medication. A history of treatment including dietary restriction for hypertension is also disqualifying.

c. *Vasomotor disturbance*, including orthostatic hypotension and Raynaud's phenomenon.

d. *Vein diseases*, thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration.

2-20. **Miscellaneous Cardiovascular Conditions**
a. Rheumatic fever during an previous 2 years; Sydenham's chorea at any age.

b. Pulmonary or systemic embolization, history of.

Section XII. HEIGHT, WEIGHT, AND BODY BUILD

2-21. Height

The causes for rejection for appointment, enlistment, and induction in relation to height standards are established by each of the military Services. Standards for the Army are—

a. Men: Height below 60 inches or over 80 inches.

b. Women: Height below 58 inches or over 80 inches.

2-22. Weight

The causes for rejection for appointment, enlistment, and induction in relation to weight standards are established by each of the military services. Standards for the Army are contained in appendix III of this regulation. Effective 1 August, 1987, all Army applicants

for initial appointment as a commissioned officer (to include appointment as a commissioned warrant officer) must meet the standards of AR 600-9. Body composition measurements may be used as the final determinant in evaluating an applicant's acceptability.

2-23. Body Build

The causes for rejection for appointment, enlistment, and induction are—

a. Congenital malformation of bones and joints. (See paras 2-9, 2-10, and 2-11.)

b. Deficient muscular development which would interfere with the completion of required training.

Section XIII. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM

2-24. Lungs, chest walls, pleura, and mediastinum

The causes for rejection for appointment, enlistment, and induction are—

a. Abnormal elevation of the diaphragm, either side.

b. Abscess of the lung.

c. Acute infectious processes of the lung, chest wall, pleura, or mediastinum, until cured.

d. Asthma, reactive airway disease, exercise-induced bronchospasm, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday. Any use of prophylactic medicine since the 12th birthday is also disqualifying regardless of symptoms.

e. Bronchitis, chronic, with pulmonary function impairment that would interfere with duty performance or restrict activities.

f. Bronchiectasis.

g. Bronchopleural fistula.

h. Bullous or generalized pulmonary emphysema.

i. Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function, or which produces dyspnea on exertion.

j. Chronic mycotic diseases of the lung including coccidioidomycosis, residual cavitation or more than a few small-sized inactive and stable residual nodules demonstrated to be due to mycotic disease.

k. Congenital malformation or acquired deformities of the chest wall that reduce the chest capacity or diminish respiratory or cardiac functions to a degree that interferes with vigorous physical exertion.

l. Empyema, residual intrapleural collection or unhealed sinuses of the chest wall following operation of other treatment for empyema.

m. Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion or significant reduction in pulmonary function tests.

n. Foreign body in trachea or bronchus.

o. Foreign body of the chest wall causing symptoms.

p. Foreign body of the lung or mediastinum causing symptoms or active inflammatory reaction.

q. Lobectomy, history of, with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.

r. Multiple cystic disease of the lung; solitary cyst, large and incapacitating.

s. New growth of the breast, mastectomy, acute mastitis, chronic cystic mastitis of more than mild degree or if symptomatic.

t. Osteomyelitis of rib, sternum, clavicle, scapula, or vertebra.

u. Other symptomatic traumatic lesions of the chest or its contents.

v. Pleurisy with effusion, within the previous 2 years of unknown origin.

w. Pneumothorax during the year preceding examination if due to simple trauma or surgery; during the 3 years preceding examination if of spontaneous origin. Surgical cor-

rection is acceptable if no significant residual disease or deformity remains and pulmonary function tests fall within normal limits. Recurrent spontaneous pneumothorax is disqualifying regardless of cause.

x. Pulmonary embolus, history of.

y. Unhealed recent fracture of ribs, sternum, clavicle, or scapula, or unstable fracture regardless of fracture age.

z. Sarcoidosis. (See para 2-40l.)

aa. Significant abnormal findings of the chest wall, lung(s), pleura or mediastinum.

ab. Silicone implants injections or saline inflated implants in breasts for cosmetic purposes. Encapsulated implants of saline or silicone and teflon are acceptable if a minimum of 9 months have elapsed since surgery and site is well healed with no complications reported.

ac. Suppurative perostitis of rib, sternum, clavicle, scapula, or vertebra.

ad. Tuberculous lesions. (See para 2-40n.)

Section XIV. MOUTH, NOSE, SINUSES, PHARYNX, TRACHEA, AND LARYNX

2-25. Mouth

The causes for rejection for appointment, enlistment, and induction are—

a. Hard palate, perforation of.

b. Harelip, unless satisfactorily repaired by surgery.

c. Leukoplakia, stomatitis or ulcerations of the mouth, if severe.

d. Ranula, if extensive. (For other tumors see paras 2-39 and 2-41.)

e. Salivary fistula or obstructive of the salivary duct.

f. 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 that does not interfere with speech or swallowing and is otherwise asymptomatic is not disqualifying. Loss of the uvula that does not interfere with speech or swallowing is not disqualifying.

2-26. Nose and Sinuses

The causes for rejection of appointment, enlistment, and induction are—

a. Allergic manifestations.

(1) Atrophic rhinitis.

(2) Allergic rhinitis, vasomotor rhinitis, if moderate or severe and not controlled by decongestants, or desensitization, or topical corticosteroid medication.

b. Anosmia or parosmia.

c. Choana, atresia or stenosis of, if symptomatic.

d. Epitaxis, chronic recurrent.

e. Nasal polyps or a history of nasal polyps, unless surgery was performed at least a year before examination and there is no evidence of recurrence.

f. Nasal septum, perforation of—

(1) Associated with the interference of function, ulceration or crusting, and when the result of organic disease.

(2) If progressive.

(3) If respiration is accompanied by a whistling sound.

g. Sinusitis, acute.

h. Sinusitis, chronic when more than mild—

(1) Evidenced by any of the following: Chronic purulent nasal discharge, large nasal polyps, hyperplastic changes of the nasal tis-

sues, or symptoms requiring frequent medical attention.

(2) Confirmed by transillumination or X-ray examination or both.

2-27. Pharynx, Trachea, and Larynx

The causes for rejection for appointment, enlistment, and induction are—

a. *Laryngeal paralysis*, sensory or motor, due to any cause.

b. *Larynx*, organic disease of, such as neoplasm, polyps, granuloma, ulceration, and chronic laryngitis.

c. *Dysphonia plicae ventricularis*.

d. *Tracheostomy or tracheal fistula*.

2-28. Other Defects and Diseases

The causes for rejection for appointment, en-

listment, and induction are—

a. *Aphonia*, or history of, or recurrent, if the cause was such as to make a subsequent attack probable.

b. *Deformities or conditions of the mouth, tongue, throat, pharynx, larynx, and nose* that interfere with mastication and swallowing of ordinary food, or with speech or breathing.

c. *Destructive syphilitic disease of the mouth, nose, throat, or larynx* (see para 2-42.).

d. *Pharyngitis and nasopharyngitis*, chronic, with positive history and objective evidence, if of such a degree as to result in excessive time lost in the military environment.

Section XV. NEUROLOGICAL DISORDERS

2-29. Neurological Disorders

The causes for rejection for appointment, enlistment, and induction are—

a. *Cerebrovascular conditions*. Any history of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriosclerosis, arteriovenous malformation, or aneurysm involving the central nervous system.

b. *Congenital malformations* if associated with neurological manifestations or if the process is expected to be progressive; meningocele even if uncomplicated.

c. *Degenerative disorders*. Any evidence or history of—

(1) Basal ganglia disease.

(2) Cerebellar and Friedreich's ataxia.

(3) Cerebral arteriosclerosis.

(4) Dementia.

(5) Multiple sclerosis or other demyelinating processes.

(6) Muscular atrophies and dystrophies of any type.

d. *Headaches*, if they are of sufficient severity or frequency to interfere with normal function.

e. *Head injury*.

(1) Applicants with a history of head injury with any of the following complications are unacceptable at any time:

(a) Late post-traumatic epilepsy manifested by generalized or focal seizures.

(b) Transient or persistent neurological deficits indicative of parenchymal central nervous system injury, such as hemiparesis or hemianopsia.

(c) Evidence of impairment of higher intellectual functions or alterations of personality as a result of injury.

(d) Persistent focal or diffuse abnormalities of the electroencephalogram, reasonably assumed to be the direct result of injury.

(e) Central nervous system shunts of all types.

(2) Applicants with a history of severe head injury with any of the following complications are unacceptable for at least 5 to 10 years after injury but may be acceptable after that time if complete neurological and neuropsychological examination and history show no residual dysfunction or complications. (See table 2-2.)

(a) Unconsciousness, amnesia, or the combination of the two exceeding 24 hours.

(b) Depressed skull fracture, with or without dural penetration.

(c) Laceration or contusion of the dura mater or the brain, or a history of penetrating brain injury, traumatic or surgical.

(d) Epidural, subdural, subarachnoid or intracerebral hematoma.

(e) Central nervous system infection such as abscess or meningitis within 6 months of head injury.

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

(g) Early post-traumatic seizures that occur only within the first week after injury and not thereafter. (Exception—seizures at the time of injury or within 15 minutes after injury do not have the same significance and may not be considered disqualifying.)

(h) Focal neurological signs.

(i) Radiographic evidence of retained metallic or bony fragments.

(j) Leptomeningeal cysts, arachnoid cysts, brain abscess, or arteriovenous fistula.

(3) History of moderate head injury associated with any of the complications below is disqualifying for at least 2 years but may be acceptable after that time if complete neurological evaluation (see table 2-2) shows no residual dysfunction or complications:

(a) Unconsciousness or amnesia or the combination of the two for a period of more than 30 minutes but less than 24 hours.

(b) Linear skull fracture.

(4) History of mild head injury; that is, loss of consciousness or amnesia or the combination of the two for less than 30 minutes, without linear skull fracture, is disqualifying for at least 1 month but may be acceptable if neurological evaluation shows no residual dysfunction or complications. (See table 2-2.)

(5) 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 until full recovery has been confirmed by complete neurological and neuropsychological evaluation.

f. *Hereditary disturbances.* Personal or family history 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. A strong family history of such a syndrome, indicating a heredity component, will be cause for rejection in the absence of clinical symptoms or signs since the onset of these illnesses may occur later in adult life.

Table 2-2. Evaluation for Risk of Head Injury Sequelae

Degree of head injury	Minimum observation time/evaluation requirements
Mild (para 2-29e(4))	1 month/complete neurological examination by a physician.
Moderate (para 2-29e(3))	2 years/complete neurological by a neurologist or internist. CT scan.
Severe (para 2-29e(2))	5 years for closed head trauma, 10 years for penetrating head trauma/complete neurological evaluation by a neurologist or neurosurgeon. CT scan. Neuropsychological evaluation.

g. *Infectious diseases.*

(1) Meningitis, encephalitis, or poliomyelitis within 1 year prior to examination, or if there are residual neurological defects that would interfere with satisfactory performance of military duty.

(2) Neurosyphilis of any form (general paresis, tabes dorsalis, meningovascular syphilis).

h. *Narcolepsy, cataplexy, and similar states, authenticated history of.*

i. *Neuritis, neuralgia, neuropathy, or radiculopathy, authenticated history of, whatever the etiology, unless—*

(1) The condition has completely subsided and the cause is determined to be of no future concern.

(2) There are no residual symptoms that could be deemed detrimental to normal function in any practical manner.

j. *Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause if there is any indication that such involvement is likely to interfere with pro-*

longed normal function in any practical manner or is progressive or recurrent.

k. Paroxysmal convulsive disorders, disturbances of consciousness, all forms of psychomotor or temporal lobe epilepsy, or history thereof, except under the following circumstances:

(1) No seizure since age 5.

(2) Individuals who have had seizures since age 5 but who, during the 5 years immediately preceding examination for military service, have been totally seizure free and have not been taking any type of anticonvulsant medication for the entire period will be considered on an individual case basis. Documentation in these cases must be from attending or consulting physicians and the original electroencephalogram tracing (not a copy) taken within the preceding 3 months must be submitted for evaluation by The Surgeon General of the Army.

l. Peripheral nerve disorder.

(1) Polyneuritis, whatever the etiology, unless—

(a) Limited to a single episode.

(b) The acute state subsided at least 1 year before examination.

(c) There are no residuals that could be expected to interfere with normal function in any practical manner.

(2) Mononeuritis or neuralgia, which is chronic or recurrent, of an intensity that is periodically incapacitating.

(3) Injury of one or more peripheral nerves, unless it is not expected to interfere with normal functions in any practical manner.

m. Any history or evidence of chronic or recurrent diseases, such as myasthenia gravis, polymyositis, muscular dystrophy, familial periodic paralysis, and myotonia congenita.

n. Evidence or history of involvement of the nervous system by a toxic, metabolic or disease process if there is any indication that such involvement is likely to interfere with prolonged normal function in any practical manner or is progressive or recurrent.

o. Tremors that will interfere with normal function.

p. Central nervous system shunts of all types.

Section XVI. MENTAL DISORDERS

Diagnostic concepts and terms utilized in paragraphs 2-30 through 2-35 are in consonance with the DSM-III manual, American Psychiatric Association, 1980.

2-30. Disorders with Psychotic Features

The causes for rejection for appointment, enlistment, and induction are a history of a mental disorder with gross impairment in reality testing. This does not include transient disorders associated with intoxication, severe stress or secondary to a toxic, infectious, or other organic process.

2-31. Affective Disorders (Mood Disorders)

The causes for rejection for appointment, enlistment, and induction are symptoms, diagnosis, or history of a major affective disorder requiring maintenance treatment or hospitalization.

2-32. Anxiety, Somatoform, Dissociative, or Factitious Disorders (alternatively may be addressed as neurotic disorders)

The causes for rejection for appointment, enlistment, and induction are—

a. History of such disorders resulting in any or all of the below:

(1) Hospitalization.

(2) Prolonged care by a physician or other professional.

(3) Loss of time from normal pursuits for repeated periods even if of brief duration, or

(4) Symptoms or behavior of a repeated nature which impaired social, school, or work efficiency.

b. History of an episode of such disorders within the preceding 12 months, which was sufficiently severe to require professional attention or absence from work or school for more than a brief period (maximum of 7 days).

2-33. Personality, Behavior, or Learning Disorders

The causes for rejection for appointment, enlistment, and induction are—

a. *Personality or behavior disorders*, as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior which, while not sufficient cause for administrative rejection, are tangible evidence of impaired characterological capacity to adapt to military service.

b. *Personality or behavior disorders* where it is evident by history, interview, or psychological testing that the degree of immaturity, instability, personality inadequacy, impulsiveness or dependency will seriously interfere with adjustment in the Army as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow workers, and other social groups.

c. *Other behavior problems* including but not limited to conditions such as authenticated evidence of functional enureses, sleepwalking, eating disorders, which are habitual or persistent, not due to an organic condition occurring beyond early adolescence or stammering or stuttering of such a degree that the individual is normally unable to express himself or herself clearly or to repeat commands. (See para 2-15.)

d. *Specific learning defects* secondary to organic or functional mental disorders sufficient to impair capacity to read and understand at a level acceptable to perform military duties.

e. *Suicide*, history of attempted suicide or serious suicidal gesture.

2-34. Psychosexual Conditions

The causes for rejection for appointment, enlistment, and induction are—

a. *Homosexual behavior*. This includes all homosexual activity except adolescent experimentation or the occurrence of a single episode of homosexual behavior while intoxicated.

b. *Transsexualism and other gender identity disorders*.

c. *Exhibitionism, transvestism, voyeurism, and other paraphilias*.

2-35. Substance Misuse

The causes for rejection for appointment, enlistment, and induction are—

a. *Chronic alcoholism* or alcohol addiction or dependence.

b. *Drug addiction* or dependence.

c. *Drug abuse* characterized by—

(1) The evidence of use of any controlled, hallucinogenic, or other intoxicating substance at the time of examination, when the use cannot be accounted for as a result of the advice of a recognized health care practitioner.

(2) Documented misuse or abuse of any controlled substance (including cannabinoids) requiring professional care within a 1-year period prior to examination. Use of marijuana or other cannabinoids (not habitual use) or experimental or casual use of other drugs short of addiction or dependence may be waived by competent authority as established by the Army if there is evidence of current drug abstinence and the individual is otherwise qualified for service.

(3) The repeated self-procurement and self-administration of any drug or chemical substance, including cannabinoids, with such frequency that it appears that the applicant has accepted the use of or reliance on these substances as part of his or her pattern of behavior.

d. *Alcohol abuse*. Repeated use of alcoholic beverages which leads to misconduct, unacceptable social behavior, poor work or academic performance, impaired physical or mental health, lack of financial responsibility, or a disrupted personal relationship within 1 year of examination.

Section XVII. SKIN AND CELLULAR TISSUES

2-36. Skin and cellular tissues

The causes for rejection for appointment, enlistment, and induction are—

a. *Acne*. Severe, or when extensive involvement of the neck, shoulders, chest, or

back would be aggravated by or interfere with the wearing of military equipment.

b. *Atopic dermatitis*. With active or residual lesions in characteristic areas (face and neck, antecubital and popliteal fossae, occa-

sionally wrists and hands), or documented history thereof.

c. Cysts.

(1) Cysts, other than pilonidal. Of such a size or location as to interfere with the normal wearing of military equipment.

(2) Cysts, pilonidal. Pilonidal cysts, if evidenced by the presence of a tumor mass or a discharging sinus.

d. Dermatitis factitia.

e. Dermatitis herpetiformis.

f. Eczema. Any type that is chronic and resistant to treatment.

g. Elephantiasis or chronic lymphedema.

h. Epidermolysis bullosa, pemphigus.

i. Fungus infections, systemic or superficial types, if extensive and not amenable to treatment.

j. Furunculosis. Extensive, recurrent, or chronic.

k. Hyperhidrosis of hands or feet. Chronic or severe.

l. Ichthyosis. Severe.

m. Keloid formation, if the tendency is marked or interferes with the wearing of military equipment.

n. Leprosy. Any type.

o. Leukemia Cutis: mycosis fungoides, Hodgkin's disease. (See para 2-41b(11)(a)2 for additional remarks on Hodgkin's disease and the potential for service qualification.)

p. Lichen planus.

q. Lupus erythematosus (acute, subacute,

or chronic) or any other dermatosis aggravated by sunlight.

r. Neurofibromatosis (Von Recklinghausen's disease).

s. Nevi or vascular tumors. If extensive, interfere with function, or exposed to constant irritation.

t. Photosensitivity. Any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria; any dermatosis aggravated by sunlight such as lupus erythematosus.

u. Psoriasis or a verified history thereof.

v. Radiodermatitis.

w. Scars that are so extensive, deep, or adherent that they may interfere with the wearing of military clothing or equipment, exhibit a tendency to ulcerate, or interfere with function.

x. Scleroderma.

y. Tattoos that will significantly limit effective performance of military service.

z. Tuberculosis. (See para 2-40n.)

aa. Urticaria. Chronic.

ab. Warts, plantar, which have materially interfered with a useful vocation in civilian life.

ac. Xanthoma. If disabling or accompanied by hyperlipemia.

ad. Any other chronic skin disorder of a degree or nature which requires frequent outpatient treatment or hospitalization, or interferes with the satisfactory performance of duty.

Section XVIII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

2-37. Spine and Sacroiliac Joints (see also para 2-11)

The causes for rejection for appointment, enlistment, and induction are—

a. Arthritis. (See para 2-11a.)

b. Complaint of a disease or injury of the spine or sacroiliac joints with or without objective signs that has prevented the individual from successfully following a physically active vocation in civilian life. Substantiation or documentation of the complaint without objective physical findings is required.

c. Deviation or curvature of spine from normal alignment, structure, or function

(Lumbar scoliosis over 20 degrees or dorsal scoliosis over 30 degrees as measured by the Cobb method, kyphosis over 55 degrees, or lordosis) or if—

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

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

(3) It is symptomatic and associated with positive physical finding(s) and demonstrable by X-ray.

d. Diseases of the lumbosacral or sacroiliac

joints of a chronic type associated with pain referred to the lower extremities, muscular spasm, postural deformities, and limitation of motion in the lumbar region of the spine.

e. Fusion involving more than two vertebrae. Any surgical fusion is disqualifying.

f. Granulomatous diseases either active or healed.

g. Healed fractures or dislocations of the vertebra. A compression fracture, involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.

h. Juvenile epiphysitis with any degree of residual change indicated by X-ray or kyphosis.

i. Ruptured nucleus pulposus (herniation of intervertebral disk) or history of operation for this condition.

j. Spina bifida when more than one vertebra is involved, if there is dimpling of the over-

lying skin, or a history of surgical repair for spina bifida.

k. Spondylolysis that is symptomatic or likely to interfere with performance of duty or limit assignments is disqualifying, even if successfully fused.

l. Weak or painful back requiring external support; that is, corset or brace.

2-38. Scapulae, Clavicles, and Ribs (see para 2-11)

The causes for rejection for appointment, enlistment, and induction are—

a. Fractures, until well healed, and until determined that the residuals thereof will not preclude the satisfactory performance of military duty.

b. Injury within the preceding 6 weeks, without fracture; or dislocation, of more than a minor nature.

c. Osteomyelitis.

d. Prominent scapulae interfering with function or with the wearing of a uniform or military equipment.

Section XIX. MISCELLANEOUS CONDITIONS AND DEFECTS AND SYSTEMIC DISEASES

2-39. General and Miscellaneous Conditions and Defects

The causes for rejection for appointment, enlistment, and induction are—

a. Allergic manifestations.

(1) Allergic rhinitis (hay fever). (See para 2-26a(2).)

(2) Asthma. (See para 2-24d.)

(3) Allergic dermatoses. (See para 2-36.)

(4) Visceral, abdominal, and cerebral allergy, if severe or not responsive to treatment.

(5) Authenticated history of moderate or severe generalized (as opposed to local) allergic reaction (including insect bites or stings) unless subsequent appropriate diagnostic venom testing has demonstrated no allergy exists. Authenticated history of severe generalized reaction to common foods; for example, milk, eggs, beef, and pork.

b. Any acute pathological condition, including acute communicable diseases, until recovery has occurred without sequelae.

c. Any deformity, abnormality, defect, or disease that impairs general functional ability to such an extent as to prevent satisfactory performance of military duty.

d. Chronic metallic poisoning, especially beryllium, manganese, and mercury. Undesirable residuals from lead, arsenic, or silver poisoning make the applicant unacceptable.

e. Cold injury, residuals of; such as frostbite, chilblain, immersion foot, trench foot, deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

f. Cold urticaria.

g. Reactive tests for syphilis such as the RPR or VDRL followed by a reactive, confirmatory fluorescent treponemal antibody absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clinical findings, the presence of reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identi-

fied or if the test reverts to a non-reactive status during an appropriate followup period (3 to 6 months).

h. Filariasis: Trypanosomiasis, amebiasis, schistosomiasis, uncinariasis (hookworm) associated with anemia, malnutrition, etc., and other similar worm or animal parasitic infestations, including the carrier states thereof, if more than mild.

i. Heat pyrexia (heatstroke, sunstroke, etc.). Documented evidence of a predisposition (including disorders of sweat mechanism and a previous serious episode), recurrent episodes requiring medical attention, or residual injury resulting therefrom (especially cardiac, cerebral, hepatic, and renal).

j. Industrial solvent and other chemical intoxication, chronic, including carbon disulfide, trichloroethylene, carbon tetrachloride, and methyl cellosolve.

k. Mycotic infection of internal organs.

l. Myositis or fibrositis, severe, chronic.

m. Presence of HTLV-III or antibody. Presence is confirmed by repeatedly reactive Enzyme-Linked Immunoassay (ELISA) serological test and positive immunoelectrophoresis (Western Blot) test, or other Food and Drug Administration approved confirmatory test.

n. Residual of tropical fevers and various parasitic or protozoal infestations that, in the opinion of the medical examiner, preclude the satisfactory performance of military duty.

2-40. Systemic Diseases

The causes for rejection for appointment, enlistment, and induction are—

a. Amyloidosis.

b. Ankylosing spondylitis.

c. Eosinophilic granuloma. Eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, should not be a

cause for rejection once healing has occurred. All other forms of the histiocytosis X spectrum should be rejected, however.

d. Lupus erythematosus, acute, subacute, or chronic.

e. Mixed connective tissue disease.

f. Polymyositis dermatomyositis complex.

g. Progressive systemic sclerosis, including CREST variant.

h. Psoriatic arthritis.

i. Reiter's disease.

j. Rheumatoid arthritis.

k. Rhabdomyolysis, or history thereof.

l. Sarcoidosis, unless there is substantiated evidence of a complete spontaneous remission of at least 2 years duration.

m. Sjogren's syndrome.

n. Tuberculosis.

(1) Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

(2) Substantiated history of one or more reactivations or relapses of tuberculosis in any form or location or other definite evidence of poor host resistance to the tubercle bacillus.

(3) Residual physical or mental defects from past tuberculosis that would preclude the satisfactory performance of duty.

(4) Individuals with a past history of active tuberculosis *more* than 2 years prior to enlistment or induction, will have received a complete course of standard chemotherapy for tuberculosis. In addition, individuals with a tuberculin reaction 10 mm or greater and without evidence of residual disease in pulmonary or non-pulmonary sites are eligible for enlistment or induction provided they have or will be treated with chemoprophylaxis in accordance with the guidelines of the American Thoracic Society and U.S. Public Health Service.

o. Vasculitis (Bechet's, Wegener's polyarteritis nodosa).

Section XX. TUMORS AND MALIGNANT DISEASES

2-41. Tumors and Malignant Diseases

The causes for rejection for appointment, enlistment, and induction are—

a. Benign tumors.

(1) Benign tumors of the head or face

that interfere with function or preclude the wearing of a face or protective mask or a helmet.

(2) Benign tumors of the eyes, ears, or upper airway that interfere with function.

(3) Benign tumors of the thyroid or other neck structures such as to interfere with function or the wearing of a uniform or military equipment.

(4) Benign tumors of the breast (male or female), chest, or abdominal wall that would interfere with military duty.

(5) Benign tumors of the respiratory, gastrointestinal, genitourinary (male or female; for external female genitalia, see para 2-14) or musculoskeletal systems that interfere with function or the wearing of a uniform or military equipment.

(6) Benign tumors of the musculoskeletal system likely to continue to enlarge, be subjected to trauma during military service or show malignant potential.

(7) Benign tumors of the skin which interfere with function, have malignant potential, interfere with military duty or the wearing of the uniform or military equipment.

b. Malignant tumors diagnosed by accepted laboratory procedures, and even though surgically removed or otherwise treated, with exceptions as noted. Individuals who have a history of childhood cancer and who have not received any surgical or medical cancer therapy for 5 years and are free of cancer will be considered, on a case-by-case basis for acceptance into the Army. Applicants must provide information about the history and present status of their cancer.

(1) Malignant tumors of the auditory canal, eye, or orbit or upper airway. (See para 2-12.)

(2) Malignant tumors of the breast (male or female).

(3) Malignant tumors of the lower airway or lung.

(4) Malignant tumors of the heart.

(5) Malignant tumors of the gastrointestinal tract, liver, bile ducts, or pancreas.

(6) Malignant tumors of the genitourinary system, male or female (for female see para 2-14). Wilm's tumor and germ cell tumors of the testis treated surgically and with current chemotherapy in childhood after 2-year disease-free interval off all treatment may be considered on a case-by-case basis for service.

(7) Malignant tumors of the musculoskeletal system.

(8) Malignant tumors of the central nervous system and its membranous coverings, unless 5 years postoperative and without otherwise disqualifying residuals of surgery or the original lesion.

(9) Malignant tumors of the endocrine glands.

(10) Malignant melanoma or history thereof. Other skin tumors such as basal cell and squamous cell carcinomas surgically removed are not disqualifying.

(11) Malignant tumors of the hematopoietic system.

(a) Lymphomatous diseases.

1. Non-Hodgkin's lymphoma (all types).

2. Hodgkin's disease, active or recurrent.

Hodgkin's disease treated with X-ray therapy or chemotherapy and disease-free off treatment for 5 years may be considered for service. Large cell lymphoma will likewise be considered on a case-by-case basis after a 2-year disease-free interval off all therapy.

(b) Leukemias. all types, except acute lymphoblastic leukemia treated in childhood without evidence of recurrence.

(c) Multiple myeloma.

Section XXI. SEXUALLY TRANSMITTED DISEASES

2-42. Sexually Transmitted Diseases

In general the finding of acute, uncomplicated venereal disease that can be expected to respond to treatment is not a cause for medical rejection for military service. The causes for rejection for appointment, enlistment, and induction are—

a. Chronic sexually transmitted disease that has not satisfactorily responded to treatment. The finding of a positive serologic test for syphilis following adequate treatment is not in itself considered evidence of chronic venereal disease. (See para 2-39.)

b. Complications and permanent residuals

of sexually transmitted disease when they are progressive, and of such a nature as to interfere with the satisfactory performance of duty, or are subject to aggravation by military service.

c. *Neurosyphilis* (see para 2-29).

CHAPTER 3
★MEDICAL FITNESS STANDARDS FOR RETENTION AND SEPARATION
INCLUDING RETIREMENT
(Short Title: RETENTION MEDICAL FITNESS STANDARDS)

Section 1. GENERAL

3-1. Scope

This chapter sets forth the various medical conditions and physical defects which may render a member unfit for further military service.

3-2. Applicability

a. These standards apply to the following individuals:

★(1) All officers and warrant officers of the Active Army, Army National Guard and Army Reserve. (See AR 135-175, AR 635-40, AR 635-100, NGR 635-100, and other appropriate regulations for administrative procedures for separation for medically unfitting conditions that existed prior to service.)

★(2) All enlisted members of the Regular Army, Army National Guard and Army Reserve. For those members who were found to have an EPTS medical condition/physical defect that should have precluded original enlistment (chapter 2) but not listed in this chapter, see paragraph 2-2 of this regulation, AR 635-200, or AR 135-178.

(3) Cadets of the United States Military Academy and the Army ROTC and Uniformed Services University of Health Sciences programs for whom the standards of this chapter have been made applicable pursuant to the provisions of paragraph 2-2*e*.

(4) Members who were placed on the Temporary Disability Retired List (see AR 635-40).

b. These standards *do not* apply in the following instances:

(1) Retention of officers, warrant officers, and enlisted personnel of the Active Army, Army National Guard, and Army Reserve in Army aviation, airborne, marine diving, ranger, or special forces training and duty, or other duties for which special medical fitness standards are prescribed.

(2) All officers, warrant officers, and enlisted personnel of the Active Army, Army Na-

tional Guard, and Army Reserve who have been permanently retired.

3-3. Policies

a. Members with conditions listed in this chapter will be evaluated by a medical board and **WILL BE REFERRED TO A PHYSICAL EVALUATION BOARD** (except for members of the Reserve Components not on active duty). However, this chapter provides general guidelines and is not to be taken as a mandate to the effect that possession of one or more of the listed conditions means automatic retirement or separation from the service. Each case will be decided upon the relevant facts and a determination of fitness or unfitness will be made by the physical evaluation boards dependent upon the abilities of the member to perform the duties of his or her office, grade, rank or rating in such a manner as to reasonably fulfill the purpose of his or her employment in the military service. When a member is being processed for separation for reasons other than physical disability, his or her continued performance of duty until he or she is scheduled for separation for other purposes creates a presumption that the member is fit for duty. In cases where the medical board determines that the member's condition is such that referral to a physical evaluation board is not appropriate, the member may request, in writing, an additional review by the MTF commander of the medical board findings and recommendations. The MTF commander will provide the member with a written report of his or her review, a copy of which will be attached to the medical board proceedings. Cases that are not resolved in this manner will be forwarded to the Commander, United States Army Health Services Command, Fort Sam Houston, TX 78234 (for all medical treatment facilities in the 50 States, the Commonwealth of Puerto Rico, and medical treatment facilities in Panama), Chief

Surgeon, United States Army, Europe, and Seventh Army, APO New York 09102 (for all medical treatment facilities in Europe) or the Surgeon, Eighth United States Army, Korea, APO San Francisco 96301 (for all medical treatment facilities in Korea and Japan).

b. The various medical conditions and physical defects which may render a member unfit to perform the duties of his or her office, grade, rank or rating by reason of physical disability are not all listed in this chapter. Further, an individual may be unfit because of physical disability resulting from the overall effect of two or more impairments even though no one of them, alone, would cause unfitness. A single impairment or the combined effect of two or more impairments may make an individual unfit because of physical disability if—

★(1) The individual is unable to perform the duties of his or her office, grade, rank, or rating in such a manner as to reasonably fulfill the purpose of his or her employment in the military service, worldwide under field conditions, or

(2) The individual's health or well-being would be compromised if he or she were to remain in the military service, or

(3) In view of the member's physical condition, his or her retention in the military service would prejudice the best interests of the Government (e.g., a carrier of communicable disease who poses a threat to others).

c. A member will not be referred to a physical evaluation board because of impairments which were known to exist at the time of his or her acceptance for military service, and which have remained essentially the same in degree of severity since acceptance and have not interfered with his or her performance of effective military service.

d. A member who has been continued in the military service under one of the programs for continuance of disabled personnel (chap 6, AR 635-40, AR 140-120 and NGR 40-501) will be referred to a physical evaluation board prior to separation or retirement processing.

e. Lack of motivation for service should not influence the medical examiner in evaluating disabilities under these standards except as it may be symptomatic of some disease process. Poorly motivated members who are medically fit for

duty will be recommended for administrative disposition.

f. An individual who is accepted for and enters the military service is presumed to be in sound physical condition except for those conditions and abnormalities recorded in his or her procurement medical records. However, this presumption may be overcome by conclusive evidence that an impairment was incurred while the individual was not entitled to receive basic pay. Likewise, the presumption that an increase in severity of such an impairment is the result of service must be overcome by conclusive evidence. Statements of accepted medical principles used to overcome these presumptions must clearly state why the impairment could not reasonably have had its inception while the member was entitled to receive basic pay, or that an increase in severity represents normal progression.

g. An impairment, its severity, and effect on an individual may be assessed upon carefully evaluated subjective findings as well as upon objective evidence. Reliance upon this determination will rest basically upon medical principles and medical judgment; contradiction of those factors must be supported by conclusive evidence. Every effort will be made to accurately record the physical condition of all members throughout their Army career. It is important, therefore, that all medical conditions and physical defects which are present be recorded, no matter how minor they may appear.

3-4. Disposition of Members Who May be Unfit Because of Physical Disability

★*a.* Members who have one or more of the conditions listed in this chapter will be referred to a physical evaluation board as prescribed in AR 40-3 and AR 635-40. When mobilization fitness standards (chap 6) are in effect, or as directed by the Secretary of the Army, individuals who may be unfit under these standards but fit under the mobilization standards will not be referred to a physical evaluation board until termination of the mobilization or as directed by the Secretary of the Army. During mobilization, those who may be unfit under both retention and mobilization standards will be processed to determine their eligibility for physical disability

benefits unless disability separation or retirement is deferred as indicated below.

b. Members on extended active duty who are being referred to a physical evaluation board under the provisions of this chapter will be advised

that they may apply for continuance on active duty as provided in chapter 6, AR 635-40.

★*c.* Members not on extended active duty who do not meet retention medical fitness standards (mobilization medical fitness standards when these

are in effect) will be processed as prescribed in AR 140-120 for members of the Army Reserve, or NGR 600-200, NGR 40-501, or NGR 40-3 for members of the Army National Guard of the United States, for disability separation or continuance in their Reserve status as prescribed in the cited regulations. Members of the Army National Guard and Army Reserve who may be unfit because of a disability resulting from injury incurred during a period of active duty training of 30 days or less, or active duty for training for 45 days ordered because of unsatisfactory performance of training duty, or inactive duty training will be processed as prescribed in AR 40-3 and AR 635-40.

d. Members on extended active duty who meet retention medical fitness standards, but may be administratively unfit or unsuitable will be reported to the appropriate commander for processing as provided in other regulations, such as AR 635-200.

e. Members on active duty who meet retention medical fitness standards, but who failed to meet procurement medical fitness standards on initial entry into the service (erroneous appointment, enlistment, or induction), may be processed for separation as provided in AR 635-120, AR 635-200, or AR 135-178 if otherwise qualified.

FOR ACTIVE ARMY MEMBERS, THE FOLLOWING SECTIONS II THROUGH XX SET FORTH, BY BROAD GENERAL CATEGORY, THOSE MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH REQUIRE MEDICAL BOARD ACTION AND REFERRAL TO A PHYSICAL EVALUATION BOARD. (USAR AND ARNG MEMBERS NOT ON ACTIVE DUTY WILL BE PROCESSED IN ACCORDANCE WITH AR 135-175, AR 135-178, AR 140-10 and NGR 600-200, AS APPROPRIATE.)

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

3-5. Abdominal and Gastrointestinal Defects and Diseases

a. Achalasia (Cardiospasm). Dysphagia not controlled by dilatation, with continuous discomfort, or inability to maintain weight.

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

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

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

e. Gastritis. Severe, chronic hypertrophic gastritis and repeated symptomatology and hospitalization, and confirmed by gastroscopic examination.

f. Hepatitis, chronic. When, after a reasonable time (1 or 2 years) following the acute stage, symptoms persist, and there is objective evidence of impairment of liver function.

g. Hernia.

(1) *Hiatus hernia.* Severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment.

(2) *Other.* If operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

h. Ileitis, regional.

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

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

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

l. Ulcer, peptic, duodenal, or gastric. Repeated hospitalization or "sick in quarters" because of frequent recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory and X-ray evidence of activity.

m. Ulcerative colitis. Except when responding well to treatment.

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

3-6. Gastrointestinal and Abdominal Surgery.

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

b. Colostomy. Per se, when permanent.

c. Enterostomy. Per se, when permanent.

d. Gastrectomy.

(1) Total, per se.

(2) Subtotal, with or without vagotomy, or gastrojejunostomy with or without vagotomy, when, in spite of good medical management, the individual:

(a) Develops "dumping syndrome" which persists for 6 months postoperatively, or

(b) Develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively, or

(c) Continues to demonstrate appreciable weight loss 6 months postoperatively.

e. Gastrostomy. Per se, when permanent.**f. Ileostomy.** Per se, when permanent.**g. Pancreatectomy.** Per se.**h. Pancreaticoduodenostomy, pancreaticogastrostomy, pancreaticojejunostomy.** Followed by more than mild symptoms of digestive disturbance, or requiring insulin.**i. Proctectomy.** Per se.**j. Proctopexy, proctoplasty, proctorrhaphy, or proctotomy.** If fecal incontinence remains after an appropriate treatment period.**Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES****3-7. Blood and Blood-Forming Tissue Diseases**

When response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision. See also paragraph 3-38.

a. Anemia.**b. Hemolytic crisis, chronic and symptomatic.****c. Leukopenia, chronic.****d. Polycythemia.****e. Purpura and other bleeding diseases.****f. Thromboembolic disease.****g. Splenomegaly, chronic.****★h. HTLV-III confirmed antibody positivity, with the presence of progressive clinical illness of immunological deficiency.** For Regular Army soldiers, and Reserve Component (RC) soldiers on active duty for more than 30 days (except for evaluation under the Walter

Reed Staging System or for training under 10 USC 270(b)), a Medical Evaluation Board (MEBD) must be accomplished and, if appropriate, the soldier must be referred to a Physical Evaluation Board (PEB) under AR 635-40. For RC soldiers not on active duty for more than 30 days or on active duty for training under 10 USC 270(b), convening of a MEBD and referral to a PEB will be determined under chapter 8, AR 635-40. Records of official diagnoses provided by private physicians (i.e., civilian doctors providing evaluations under contract with DA/DoD, or civilian public health officials) concerning the presence of progressive clinical illness or immunological deficiency in RC soldiers may be used as a basis for administrative action under, for example, AR 135-133, AR 135-175, AR 135-178, AR 140-10, NGR 600-200, or NGR 635-100, as appropriate.

Section IV. DENTAL**3-8. Dental Diseases and Abnormalities of the Jaws**

Diseases of the jaws or associated tissues when, following restorative surgery, there re-

main residuals which are incapacitating, or interfere with the individual's satisfactory performance of military duty, or leave unsightly deformities which are disfiguring.

Section V. EARS AND HEARING**3-9. Ears****a. Infections of the external auditory canal.** Chronic and severe, resulting in thickening and excoriation of the canal or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.**b. Malfunction of the acoustic nerve.** Evaluate functional impairment of hearing under paragraph 3-10.**c. Mastoiditis, chronic.** Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.**d. Mastoiditis, chronic, following mas-**

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toideotomy. Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care or hospitalization.

e. *Meniere's syndrome*. Recurring attacks

of sufficient frequency and severity as to interfere with the satisfactory performance of duty, or requiring frequent or prolonged medical care or hospitalization.

the satisfactory performance of duty, or requiring frequent or prolonged medical care or hospitalization.

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

3-10. Hearing

Trained and experienced personnel will not be categorically disqualified if they are capable of effective performance of duty with a hearing aid. Ordinarily a hearing defect will not be considered sufficient reason for initiating disability separation or retirement processing. Most individuals having a hearing defect can be returned to duty with appropriate as-

signment limitations. The following is a guide in referring individuals with hearing defects for physical disability separation or retirement processing:

a. When a member is being evaluated for disability separation or retirement because of other impairments, the hearing defect will be carefully evaluated and considered in computing the total disability.

★*b.* A member may be considered for physical disability separation or retirement if, at the time he or she is being considered for separation or retirement for some other administrative reason, the medical examination discloses a substantial hearing defect.

★*c.* Rescinded.

Section VI. ENDOCRINE AND METABOLIC DISORDERS

3-11. Endocrine and Metabolic Disorders

a. Acromegaly. With severe function impairment.

b. Adrenal hyperfunction. Which does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.

c. Diabetes insipidus. Unless mild and patient shows good response to treatment.

d. Diabetes mellitus. When proven to require hypoglycemic drugs in addition to restrictive diet for control.

e. Goiter. With symptoms of obstruction to breathing with increased activity, unless correctable.

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

g. Hyperinsulinism. When caused by a malignant

tumor or when the condition is not readily controlled.

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

i. Hyperthyroidism. Severe symptoms of hyperthyroidism, with or without evidence of goiter, which do not respond to treatment.

j. Hypofunction, adrenal cortex. Requiring medication for control.

k. Hypoparathyroidism. With objective evidence and severe symptoms not controlled by maintenance therapy.

l. Hypothyroidism. With objective evidence and severe symptoms not controlled by medication.

m. Osteomalacia. Residuals after therapy of such nature or degree as to preclude the satisfactory performance of duty.

Section VII. EXTREMITIES

3-12. Upper Extremities

(See also para 3-14).

a. Amputations. Amputation of part or parts of an upper extremity equal to or greater than any of the following:

(1) Of a thumb proximal to the interphalangeal joints.

(2) Of two fingers of one hand, other than the little finger, at the proximal interphalangeal joints.

(3) Of one finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the

same hand at the interphalangeal joint.

b. Joint ranges of motion. Motion which does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated and described in TM 8-640.

(1) *Shoulder.*

(a) Forward elevation to 90°.

(b) Abduction to 90°.

(2) *Elbow.*

(a) Flexion to 100°.

(b) Extension to 60°.

(3) *Wrist*. A total range extension plus flexion of 15°.

(4) *Hand*. For this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints (TM 8-640).

(a) An active flexor value of combined joint motions of 135° in each of two or more fingers of the same hand.

(b) An active extensor value of combined joint motions of 75° in each of the same two or more fingers.

(c) Limitation of motion of the thumb that precludes opposition to at least two finger tips.

c. *Recurrent dislocations of the shoulder*. When not repairable or surgery is contraindicated.

3-13. Lower Extremities

(See para 3-14.)

a. Amputations.

(1) Loss of toes which precludes the ability to run or walk without a perceptible limp, and to engage in fairly strenuous jobs.

(2) Any loss greater than that specified above to include foot, leg, or thigh.

b. Feet.

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

(2) *Pes Planus*: Symptomatic, more than moderate, with pronation on weight bearing which prevent the wearing of a military shoe, or when associated with vascular changes.

(3) *Talipes cavus* when moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, and which prevent the wearing of a military shoe.

c. Internal derangement of the knee.

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

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

d. *Joint ranges of motion*. Motion which does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated and described in TM 8-640.

(1) Hip.

(a) Flexion to 90°.

(b) Extension to 0°.

(2) Knee.

(a) Flexion to 90°.

(b) Extension to 15°.

(3) Ankle.

(a) Dorsiflexion to 10°.

(b) Plantar Flexion to 10°.

e. *Shortening of an extremity* which exceeds 2 inches.

3-14. Miscellaneous

(See para 3-12 and 3-13.)

a. Arthritis.

(1) *Arthritis due to infection*. Arthritis due to infection associated with persistent pain and marked loss of function, with objective X-ray evidence and document history of recurring incapacity for prolonged periods. For arthritis due to gonococcal or tuberculous infection, see paragraphs 3-35k(7) and 3-40b.

(2) *Arthritis due to trauma*. When surgical treatment fails or is contraindicated and there is functional impairment of the involved joints so as to preclude the satisfactory performance of duty.

(3) *Osteoarthritis*. Severe symptoms associated with impairment of function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

(4) *Rheumatoid arthritis or rheumatoid myositis*. Substantiated history of frequent incapacitating episodes and currently supported by objective and subjective findings.

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

c. Fractures.

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

(2) *Nonunion of fracture*. When after an appropriate healing period the nonunion precludes satisfactory performance of duty.

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

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

d. Joints.

(1) *Arthroplasty*. Severe pain, limitation of motion, and of function.

(2) *Bony or fibrous ankylosis*. With severe pain

involving major joints or spinal segments in unfavorable position, and with marked loss of function.

(3) *Contracture of joint*. Marked loss of function and the condition is not remediable by surgery.

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

(5) *Prosthetic replacement of major joints*.

e. Muscles.

(1) *Flacid paralysis of one or more muscles*. Loss of function which precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.

(2) *Spastic paralysis of one or more muscles*. Loss of function which precludes the satisfactory

performance of military duty.

f. Myotonia congenita.

★*g. Osteitis deformans (Paget's disease)*. Involvement of single or multiple bones with resultant deformities or symptoms severely interfering with function.

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

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

j. Tendon transplant. Fair or poor restoration of function with weakness which seriously interferes with the function of the affected part.

Section VIII. EYES AND VISION

3-15. Eyes

a. Active eye disease. Active eye disease, or any progressive organic disease, regardless of the stage of activity, which is resistant to treatment and affects the distant visual acuity or visual field so that—

(1) Distant visual acuity does not meet the standard stated in paragraph 3-16e, or

(2) The diameter of the field of vision in the better eye is less than 20°.

b. Aphakia, bilateral.

c. Atrophy of optic nerve. Due to disease.

d. Glaucoma. If resistant to treatment or affecting visual fields as in a(2) above, or if side effects of required medication are functionally incapacitating.

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

f. Diseases and infections of the eye. When chronic, more than mildly symptomatic, progressive, and resistant to treatment after a reasonable period.

g. Ocular manifestations of endocrine or metabolic disorders. Not unfitting, per se. However, residuals or complications, or the underlying disease may be unfitting.

h. Residuals or complications of injury. When progressive or when reduced visual acuity does not meet the criteria stated in paragraph 3-16e.

i. Retina, detachment of.

(1) *Unilateral.*

(a) When visual acuity does not meet the standard stated in paragraph 3-16e.

(b) When the visual field in the better eye is constricted to less than 20°.

(c) When uncorrectable diplopia exists.

(d) When detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

(2) *Bilateral*. Regardless of etiology or results of corrective surgery.

3-16. Vision

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

b. Binocular diplopia. Not correctable by surgery, and which is severe, constant, and in zone less than 20° from the primary position.

c. Hemianopsia. Of any type, if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not considered to render an individual unfit.

d. Night blindness. Of such a degree that the individual requires assistance in any travel at night.

e. Visual acuity.

(1) Vision which cannot be corrected with spectacle lenses to at least: 20/60 in one eye and 20/60 in the other eye, or 20/50 in one eye and 20/80 in

the other eye, or 20/40 in one eye and 20/100 in the other eye, or 20/30 in one eye and 20/200 in the other eye, or 20/20 in one eye and 20/800 in the other eye, or

- (2) An eye has been enucleated.
f. Visual field. Bilateral concentric constriction to less than 20°.

Section IX. GENITOURINARY SYSTEM

3-17. Genitourinary System

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

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

c. Endometriosis. Symptomatic and incapacitating to a degree which necessitates recurrent absences of more than 1 day.

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

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

f. Kidney.

(1) *Calculus in kidney.* Bilateral, symptomatic, and not responsive to treatment.

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

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

(4) *Glomerulonephritis, chronic.*

(5) *Hydronephrosis.* More than mild, bilateral, and causing continuous or frequent symptoms.

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

(7) *Nephritis, chronic.*

(8) *Nephrosis.*

(9) *Perirenal abscess.* Residuals of a degree which preclude the satisfactory performance of duty.

(10) *Pyelonephritis or pyelitis.* Chronic, which has not responded to medical or surgical treatment, with evidence of hypertension, eye-ground changes, or cardiac abnormalities.

(11) *Pyonephrosis.* Not responding to treatment.

g. Menopausal syndrome, physiologic or artificial. More than mild mental and constitutional symptoms.

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

i. Urethritis, chronic. Not responsive to treatment and necessitating frequent absences from duty.

3-18. Genitourinary and Gynecological Surgery

a. Cystectomy.

b. Cystoplasty. If reconstruction is unsatisfactory or if residual urine persists in excess of 50 cc or if refractory symptomatic infection persists.

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

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

e. Nephrostomy. If drainage persists.

f. Oophorectomy. When following treatment and convalescent period there remain more than mild mental or constitutional symptoms.

g. Pyelostomy. If drainage persists.

h. Ureterocolostomy.

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

j. Ureteroileostomy cutaneous.

k. Ureteroplasty.

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

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

l. Ureterosigmoidostomy.

m. Ureterostomy. External or cutaneous.

n. Urethrostomy. Complete amputation of the penis or when a satisfactory urethra cannot be restored.

o. Kidney transplant. Recipient of a kidney transplant.

Section X. HEAD AND NECK

3-19. Head

(See also para 3-27.)

Loss of substance of the skull with or without prosthetic replacement when accompanied by moderate residual signs and symptoms such as described in paragraph 3-28.

3-20. Neck

(See also para 3-11.)

Torticollis (wry neck). Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

★ Section XI. HEART AND VASCULAR SYSTEM

3-21. Heart

a. *Coronary heart disease* associated with—

(1) Myocardial infarction, angina pectoris or congestive heart failure due to fixed obstructive coronary artery disease or coronary artery spasm.*

(2) Myocardial infarction with normal coronary artery anatomy.*

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

(4) Fixed obstructive coronary artery disease, asymptomatic, but with objective evidence of myocardial ischemia.*

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

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

d. *Heart block* (second degree or third degree AV block) and symptomatic bradyarrhythmias, even in the absence of organic heart disease or syncope. Wenckebach second degree heart block occurring in healthy asymptomatic individuals without evidence of organic heart disease is *not* a case for referral to a physical evaluation board. None of these conditions is cause for medical board referral to a physical evaluation board when associated with recognizable

temporary precipitating conditions; e.g., perioperative period, hypoxia, electrolyte disturbance, drug toxicity, or during an acute illness.

e. *Myocardial disease*, New York Heart Association or Canadian Cardiovascular Society Functional Class II or worse (app VII).

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

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

h. *Pericarditis*.

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

(2) Chronic serous pericarditis.

i. *Valvular heart disease*. Cardiac insufficiency at functional capacity of Class II or worse as defined by the New York Heart Association (app VII). A

*Individuals with myocardial infarction and with or without coronary artery bypass surgery or percutaneous coronary angioplasty should have the option of a 120-day trial of duty based upon physician recommendation when the individual is asymptomatic without objective evidence of myocardial ischemia, and when other functional assessment (such as coronary angiography, exercise testing, and newly developed techniques) indicates that it is medically advisable. Prior to commencing the trial of duty period, a medical board will be accomplished in all cases and a physical activity prescription provided by a physician on DA Form 3349 (Physical Profile). Upon completion of the trial of duty period, a detailed report from the commander or supervisor will be incorporated in the medical board record and will clearly describe the individual's ability to accomplish assigned duties and ability to perform physical activity. An addendum to the medical board will be accomplished by a cardiologist or internist and will include the individual's interim history, present condition, prognosis, and the final recommendations. For Reserve Component members not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

diagnosis made during the initial period of service or enlistment which is determined to be a residual of a condition which existed prior to entry in the service is a cause for medical board referral to a physical evaluation board regardless of the degree of severity.

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

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

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

3-22. Vascular System

a. Arteriosclerosis obliterans. When any of the following pertain:

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

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

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

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

c. Aneurysms. Aneurysm of any vessel not correctable by surgery, aneurysm corrected by surgery after a period of up to 90 days trial of duty that results in the individual's inability to perform satisfactory duty. (Prior to commencing the trial of duty period a medical board will be accomplished in all cases.) At the completion of the trial of duty period a detailed report from the commander or supervisor will be incorporated with an addendum to the medical board in all cases. For Reserve Components not

on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

d. Periarthritis nodosa. With definite evidence of functional impairment.

e. Chronic venous insufficiency (post-phlebotic syndrome). When more than mild and symptomatic despite elastic support.

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

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

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

i. Varicose veins. Severe and symptomatic despite therapy.

3-23. Miscellaneous

a. Erythromelalgia. Persistent burning pain in the soles or palms not relieved by treatment.

b. Hypertensive cardiovascular disease and hypertensive vascular disease.

(1) Diastolic pressure consistently more than 110 millimeters of mercury following an adequate period of therapy in an ambulatory status, or

(2) Any documented history of hypertension, regardless of the pressure values, if associated with one or more of the following:

(a) More than minimal changes in the brain.

(b) Heart disease.

(c) Kidney involvement, with moderate impairment of renal function.

(d) Grade III (Keith-Wagner-Barker) changes in the fundi.

c. Rheumatic fever, active, with or without heart damage. Recurrent attacks.

3-23.1 Surgery and other invasive procedures involving the heart, pericardium, or vascular system. This includes newly developed techniques or prostheses which are not otherwise covered below:

a. Permanent prosthetic valve implantation.

b. Implantation of permanent pacemakers, anti-tachycardia and defibrillator devices, and similar newly developed devices.

c. Reconstructive cardiovascular surgery employing exogenous grafting material.

d. Vascular reconstruction, after a period of 90 days trial of duty when medically advisable, that results in the individual's inability to perform satisfactory duty. When the surgery includes a median sternotomy, the trial of duty period will be 120 days and the individual will be restricted from lifting 25 pounds or more, performing pullups, performing pushups, or as otherwise prescribed by a physician for a period of 90 days from the date of surgery on DA Form 3349. Prior to commencing the trial of duty period, a detailed report from the commander or supervisor will be incorporated in the medical board record and will clearly describe the individual's ability to accomplish the assigned duties and ability to perform physical activity. An addendum to the medical board will be accomplished and will include the individual's interim history, present condition, prognosis, and the final recommendations. For Reserve Component members not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

e. Coronary artery revascularization. Individuals should have the option of a 120-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as exercise testing and newly developed techniques) indicates that it is medically advisable. Any individual undergoing median sternotomy for surgery will be restricted from lifting 25 pounds or more, performing pullups, performing pushups, or as otherwise prescribed by a physician for a period of 90 days from the date of surgery on DA Form 3349. Prior to commencing the trial of duty period, a medical board will be accomplished in all cases. Upon completion of the trial of duty period, a detailed report from the commander or supervisor will be incorporated in the medical board record and will clearly describe the individual's ability to accomplish assigned duties and ability to perform physical activity. An addendum to the medical board will be accomplished by a cardiologist or internist and will include the individual's interim history, present condition, prognosis, and the final recommendations. For Reserve Component members not on active duty, cases will be considered on an individual basis using guidelines

established jointly by the command waiver authority and The Surgeon General.

f. Heart or heart-lung transplantation.

g. Coronary or valvular angioplasty procedures. Individuals should have the option of a 180-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as cardiac catheterization, exercise testing, and newly developed techniques) indicates that it is medically advisable. Prior to commencing a trial of duty period, a medical board will be accomplished in all cases and a physical activity prescription provided by a physician on DA Form 3349. Upon completion of the trial of duty period, a detailed report from the commander or supervisor will be incorporated in the medical board record and will clearly describe the individual's ability to accomplish assigned duties and ability to perform physical activity. An addendum to the medical board will be accomplished by a cardiologist or internist and will include the individual's interim history, present condition, prognosis and the final recommendations. For Reserve Component members not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

h. Cardiac arrhythmia ablation procedures. Individuals should have the option of a 180-day trial of duty based upon physician recommendation when asymptomatic, and no evidence of any unfitting arrhythmia noted in paragraph 3-21. Prior to commencing the trial of duty period, a medical board will be accomplished by a cardiologist or internist and will include the individual's interim history, present condition, prognosis and an addendum will reflect the final recommendations. For Reserve Component members not on active duty, cases will be considered on an individual basis using guidelines established jointly by the command waiver authority and The Surgeon General.

3-23.2 Trial of Duty and Profiling

The following guidelines supplement chapter 9. Individuals returning to a trial of duty will be given a temporary P3 profile with specific written limitations and instructions for physical and cardiovascular rehabilitation on DA Form 3349. When the addendum to the medical board is accomplished, a permanent numerical designator in the "P" factor of

the physical profile will be given based on functional assessment as follows:

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

b. Numerical designator "3"—Individuals who are asymptomatic, but with objective evidence of myocardial ischemia or other cardiovascular functional abnormality.

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

Section XII. LUNGS AND CHEST WALL

3-24. Tuberculous Lesions

(See TB MED 236.)

a. Pulmonary tuberculosis.

(1) When the disease of a member on active duty is found to be not incident to military service, or when treatment and return to useful duty will probably require more than 15 months including an appropriate period of convalescence, or if expiration of service will occur before completion of period of hospitalization. (Career members who express a desire to reenlist after treatment may extend their enlistment to cover period of hospitalization.)

(2) When a member of the U.S. Army Reserve not on active duty has disease that will probably require treatment for more than 12 to 15 months including an appropriate period of convalescence before he or she will be capable of performing full-time military duty. Individuals who are retained in the Reserve while undergoing treatment may not be called or ordered to active duty (including mobilization), active duty for training, or inactive duty training during the period of treatment and convalescence.

★(3) A member of the ARNG, not on active duty, will be separated from the ARNG in accordance with the provisions of NGR 635-100 (officers) or NGR 635-200 (enlisted). Such members will be permitted to reenlist or be reappointed in the ARNG if they meet the standards of this chapter following a 12- to 15-month period of treatment including an appropriate period of convalescence.

b. Tuberculous emphysema.

3-25. Nontuberculous Lesions

★a. *Asthma*. Of sufficient severity to interfere with satisfactory performance of duty, or with frequent attacks not controlled by oral bronchodilators or inhaled medication.

b. *Atelectasis, or massive collapse of the lung*. Moderately symptomatic with paroxysmal cough at

frequent intervals throughout the day, or with moderate emphysema, or with residuals or complications which require repeated hospitalization.

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

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

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

f. *Diaphragm, congenital defect*. Symptomatic.

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

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

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

j. *Pneumothorax, spontaneous*. Repeated episodes of pneumothorax not correctable by surgery.

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

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

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

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

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

p. Stenosis, bronchus. Severe stenosis associated

with repeated attacks of bronchopulmonary infections requiring hospitalization of such frequency as to interfere with the satisfactory performance of duty.

3-26. Surgery of the Lungs and Chest

Lobectomy. If pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

Section XIII. MOUTH, ESOPHAGUS, NOSE, PHARYNX, LARYNX, AND TRACHEA

3-27. Mouth, Esophagus, Nose, Pharynx, Larynx, and Trachea

a. Esophagus.

(1) Achalasia unless controlled by medical therapy.

(2) Esophagitis, persistent and severe.

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

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

b. Larynx.

(1) Paralysis of the larynx characterized by bi-

lateral vocal paralysis seriously interfering with speech and adequate airway.

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

c. Obstructive edema of glottis. If chronic, not amenable to treatment and requiring tracheotomy.

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

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

f. Trachea. Stenosis of trachea.

Section XIV. NEUROLOGICAL DISORDERS

3-28. Neurological Disorders

a. Amyotrophic sclerosis, lateral.

b. Atrophy, muscular, myelopathic. Includes severe residuals of poliomyelitis.

c. Atrophy, muscular. Progressive muscular atrophy.

d. Chorea. Chronic, progressive chorea.

e. Convulsive disorders. (This does not include convulsive disorders caused by, and exclusively incident to the use of, alcohol.) When seizures are not adequately controlled (complete freedom from seizure of any type) by standard drugs which are relatively nontoxic and which do not require frequent clinical and laboratory re-evaluation.

f. Friedreich's ataxia.

g. Hepatolenticular degeneration.

h. Migraine. When the cause is unknown, and manifested by frequent incapacitating attacks or attacks which last for several consecutive days, and unrelieved by treatment.

i. Multiple sclerosis.

j. Myelopathy, transverse.

k. Narcolepsy. When attacks are not controlled by medication.

★*l. Paralysis agitans (Parkinson's disease).*

m. Peripheral nerve conditions.

(1) *Neuralgia.* When symptoms are severe, persistent, and not responsive to treatment.

(2) *Neuritis.* When manifested by more than moderate, permanent functional impairment.

(3) *Paralysis due to peripheral nerve injury.* When manifested by more than moderate, permanent functional impairment.

n. Syringomyelia.

o. General. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, convulsions not controlled by medications, 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 de-

gree as to definitely interfere with the performance of duty.

Section XV. MENTAL DISORDERS

Diagnostic concepts and terms utilized in this section are in consonance with the Diagnostic and Statistical Manual, Third Edition (DSM-III), American Psychiatric Association, 1980.

★ 3-29. Disorders with Psychotic Features

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

3-30. Affective Disorders (Mood Disorders)

Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization, necessity for limitations of duty or duty in protected environment or resulting in interference with effective military performance.

3-31. Anxiety, Somatoform, or Dissociative Disorders (Alternatively may be addressed as Neurotic Disorders)

Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization, necessity for limitations of duty or duty in protected environment or resulting in interference with effective military performance.

3-32. Organic Mental Disorders

Persistence of symptoms or associated personality

change sufficient to interfere definitively with the performance of duty or social adjustment.

3-32.1. Personality, Psychosexual or Factitious Disorders; Disorders of Impulse Control Not Elsewhere Classified; Substance Use Disorders

These conditions may render an individual administratively unfit rather than unfit because of physical disability. Interference with performance of effective duty in association with these conditions will be dealt with through appropriate administrative channels.

3-32.2. Adjustment Disorders

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

3-32.3. Disorders Usually First Evident in Infancy, Childhood or Adolescence

These disorders, to include primary mental deficiency or special learning defects, or developmental disorders do not render an individual unfit because of physical disability but may result in administrative unfitness if the individual does not show satisfactory performance of duty.

Section XVI. SKIN AND CELLULAR TISSUES

3-33. Skin and Cellular Tissues

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

b. *Atopic dermatitis*. More than moderate or requiring periodic hospitalization.

c. *Amyloidosis*. Generalized.

d. *Cysts and tumors*. See section XIX.

e. *Dermatitis herpetiformis*. Which fails to respond to therapy.

f. *Dermatomyositis*.

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

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

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

j. *Epidermolysis bullosa*.

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

l. *Exfoliative dermatitis*. Chronic.

m. *Fungus infections, superficial or systemic types*. If not responsive to therapy and interfering with the satisfactory performance of duty.

n. *Hidradenitis suppurativa and folliculitis decalvans*.

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

p. Leukemia cutis and mycosis fungoides.

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

r. Lupus erythematosus. Chronic discoid variety with extensive involvement of the skin and mucous membranes and when the condition does not respond to treatment.

s. Neurofibromatosis. If repulsive in appearance or when interfering with the satisfactory performance of duty.

t. Panniculitis. Relapsing, febrile, nodular.

u. Parapsoriasis. Extensive and not controlled by treatment.

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

w. Psoriasis. Extensive and not controllable by

treatment.

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

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

z. Scleroderma. Generalized, or of the linear type which seriously interferes with the function of an extremity.

aa. Tuberculosis of the skin. See paragraph 3-35k(7).

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

ac. Urticaria. Chronic, severe, and not amenable to treatment.

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

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

Section XVII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

3-34. Spine, Scapulae, Ribs, and Sacroiliac Joints (See also para 3-14.)

a. Congenital anomalies.

(1) *Dislocation, congenital, of hip.*

(2) *Spina bifida.* Demonstrable signs and moderate symptoms of root or cord involvement.

(3) *Spondylolysis or spondylolisthesis.* With more than mild symptoms resulting in repeated outpatient visits, or repeated hospitalization, or significant assignment limitations.

b. Coxa vara. More than moderate with pain, de-

formity, and arthritic changes.

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

d. Kyphosis. More than moderate, interfering with function, or causing unmilitary appearance.

e. Scoliosis. Severe deformity with over 2 inches deviation of tips of spinous process from the midline.

Section XVIII. SYSTEMIC DISEASES, AND MISCELLANEOUS CONDITIONS AND DEFECTS

3-35. Systemic Diseases

a. Amyloidosis.

b. Blastomycosis.

c. Brucellosis. Chronic with substantiated, recurring febrile episodes, severe fatigability, lassitude, depression, or general malaise.

d. Leprosy. Any type which seriously interferes with performance of duty or is not completely responsive to appropriate treatment.

e. Lupus erythematosus disseminated, chronic.

f. Myasthenia gravis.

g. Mycosis—active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals which themselves are unfitting.

h. Panniculitis, relapsing, febrile, nodular.

i. Porphyria cutanea tarda.

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

h. Tuberculosis.

(1) Meningitis, tuberculous.

(2) Pulmonary tuberculosis, tuberculous empyema, and tuberculous pleurisy.

(3) Tuberculosis of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.

(4) Tuberculosis of the female genitalia.

(5) Tuberculosis of the kidney.

(6) Tuberculosis of the larynx.

(7) Tuberculosis of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery will be evaluated on an individual basis considering the associated involvement, residuals and complications.

3-36. General and Miscellaneous Conditions and Defects

a. Allergic manifestations.

(1) *Allergic rhinitis.* See paragraphs 3-27*d* and *e*.

(2) *Asthma.* See paragraph 3-25*a*.

(3) *Allergic dermatoses.* See paragraph 3-33.

(4) *Visceral, abdominal, or cerebral allergy.* Severe or not responsive to therapy.

b. Cold injury. Evaluate on severity and extent of residuals, or loss of parts as outlined in paragraphs 3-12 and 3-13. See also TB MED 81.

c. Miscellaneous conditions and defects. Condi-

tions and defects, individually or in combination, if—

(1) The conditions result in interference with satisfactory performance of duty as substantiated by the individual's commander or supervisor.

(2) The individual's health or well-being would be compromised if he or she were to remain in the military service, or

(3) In view of the member's condition, his or her retention in the military service would prejudice the best interests of the government (e.g., a carrier of communicable disease who poses a health threat to others). Subject to the limitations set forth in paragraph 3-3*b* of this regulation, questionable cases including those involving latent impairment and/or those when no single impairment but a combination of two or more impairments may be considered to render the individual unfit will be referred to physical evaluation boards.

d. Exceptionally, as regards members of the National Guard of the United States and the Army Reserve, not on active duty, medical conditions and physical defects of a progressive nature approaching the levels of severity described as unfitting in other parts of this chapter, when unfitness within a short time may be expected.

Section XIX. TUMORS AND MALIGNANT DISEASES

3-37. Malignant Neoplasms

a. Malignant neoplasms which are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

b. Malignant neoplasms in individuals on active duty when they are of such a nature as to preclude satisfactory performance of duty, and treatment is refused by the individual.

c. Presence of malignant neoplasms or reasonable suspicion thereof when an individual not on active duty is unwilling to undergo treatment or appropriate diagnostic procedures.

d. Malignant neoplasms, when on evaluation for administrative separation or retirement, the observation period subsequent to treatment is deemed inadequate in accordance with accepted medical principles.

3-38. Neoplastic Conditions of Lymphoid and Blood-Forming Tissues

Neoplastic conditions of the lymphoid and blood-forming tissues.

3-39. Benign Neoplasms

a. Benign tumors, except as noted in b below, are not generally a cause of unfitness because they are usually remediable. Individuals who refuse treatment should be considered unfit only if their condition precludes their satisfactory performance of military duty.

b. The following upon the diagnosis thereof, are normally considered to render the individual unfit for further military service.

(1) Ganglioneuroma.

(2) Meningeal fibroblastoma, when the brain is involved.

Section XX. ★SEXUALLY TRANSMITTED DISEASES

★ 3-40. Sexually Transmitted Diseases

a. *Symptomatic neurosyphilis* in any form.

b. *Complications or residuals of sexually trans-*

mitted disease of such chronicity or degree that the individual is incapable of performing useful duty.

CHAPTER 4
MEDICAL FITNESS STANDARDS FOR FLYING DUTY¹
(Short Title: MEDICAL FITNESS STANDARDS FOR FLYING)

★Section I. GENERAL

4-1. Scope.

This regulation sets forth medical conditions and physical defects which are causes for rejection for selection, training, and retention of—

- a. *Army aviators.*
- b. *Military and Department of the Army civilian (DAC) air traffic controllers.²*
- c. *Department of the Army and contract civilian pilots.*
- d. *Flight surgeons.*
- e. *Individuals ordered by competent authority to participate in regular and frequent aerial flights as nonrated personnel.*

4-2. Classes of Medical Standards for Flying and Applicability

The established classes of medical fitness standards for flying duties and their applicability are as follows:

a. Class 1 or 1A standards apply (AR 611-85 and AR 611-110) to—

- (1) *Individuals being considered for training leading to an Army aviator aeronautical rating.*
- (2) *Personnel selected for such training until the beginning of flight training.*
- (3) *Individuals being considered for the Army ROTC Flight Training Program or US Military Academy Specialty Training Program (Aviation).*

b. Class 2 standards apply to—

- (1) *Individuals who have successfully completed an ROTC or USMA flight training course.*
- (2) *Student aviators while in flight training.*

(3) *Applicants for HQDA programs for appointment and rating by reason of civilian-acquired aeronautical skills (see para 7-21).*

(4) *Individuals qualified for aviation service as Army aviators.*

(5) *Flight surgeons and student flight surgeons (for administrative purposes only, Commander, US Army Aeromedical Center (USAAMC), designates these as "Class 2F").*

(6) *Medical officers, medical students, physician assistants, and all other personnel being considered for or while in training in the Army flight surgeon's course; and Army personnel applying for and enrolled in Navy or Air Force primary courses in aviation medicine (for administrative purposes only, Cdr, USAAMC, designates these as "Class 2F").*

(7) *Department of the Army pilots, and civilian pilots who are employees of firms under contract to the Department of the Army (not including aircraft manufacturers) (see paras 4-3b and 10-26k for further guidance on DAC and contract personnel).*

(8) *Army aviators being considered for return to aviation service.*

(9) *Certain senior career officers (para 7-22).*

c. *Class 2A standards apply to Army military and Department of the Army civilian air traffic controllers.*

(1) *Class 2A standards are currently identical to those contained in Part 67, Federal Aviation Regulations (FAR) (administered per the FAA Guide to Aviation Medical Examiners) except that military air traffic control personnel must also meet the applicable procurement or retention standards of chapters 2 and 3, and appendix III, which apply to general military service.*

(2) *The standards specified in Part 67, FAR are the basis on which FAA Second Class Airman Medical Certificates may be issued to quali-*

¹For the purpose of this regulation, "flying duty" is synonymous with "flight status" and "qualified for aviation service." All provisions apply to the Reserve Components except as noted.

²Provisions of this chapter applicable to civilian personnel have been reviewed by the Federal Aviation Administration (FAA).

fied military and civilian ATC personnel (see para 10-26*k*), with the following exceptions:

(a) ATC personnel (civilian or military) who illegally use drugs are medically unfit for further ATC duty.

(b) The ARMA and RAT apply to ATC personnel. (See paras 4-30 and 31.)

(c) Local national, third country, or other non-US citizen air traffic controllers employed by or on behalf of the US Army are included in the requirement for ATCs to meet the standards of FAR Part 67; however, host nation laws or status of forces agreements may take precedence.

(d) Genitourinary system. (See para 4-13.)

(e) *Malaria*. (See para 4-27*d*.)

(f) Other diseases and conditions disqualifying under paragraph 4-27*h*.

(3) Active duty ATC personnel who do not meet standards specified in FAR Part 67 but who have been found qualified by FAA on the basis of demonstrated ability ("Waiver") or with a limitation will be allowed to continue Army air traffic control duties only with the concurrence of Cdr, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362. The Cdr, USAAMC will, in evaluation of senior ATC personnel (E8, E9) whose duties are normally administrative or supervisory, generally consider the decreased risk of direct adverse impact on aviation safety by reason of such duties in determining whether or not an Army waiver is recommended for disqualifying conditions.

d. Class 3 standards apply to individuals ordered by competent authority to participate in regular and frequent aerial flights but who are not engaged in actual control of aircraft, including air ambulance attendants, aeromedical physician assistants (after completion of training in aviation medicine; Class 2 standards apply for selection and while in training), crew chiefs, observers, gunners and others.

4-3. Disposition of Reports of Medical Examination of Personnel Who Do Not Meet These Standards

a. Applicants (Classes 1, 1A and 2). The reports of medical examination pertaining to appli-

cants who do not meet the medical fitness standards for flying as prescribed herein will nevertheless be processed for review by the Cdr, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362, as prescribed in the appropriate procurement regulation.

b. Personnel on flying status/qualified for aviation service.

(1) Military personnel who do not meet medical fitness standards for flying will be immediately medically suspended from flying as prescribed by AR 600-105 unless they have previously been continued in flying status for the same defect by designated higher authority, in which case they may be permitted to fly until continuance of waiver is confirmed, provided the condition has not significantly worsened and flying safety and the individual's well-being are not compromised.

(2) Department of the Army civilian pilots and contract civilian pilots who do not meet Army Class 2 standards will be evaluated for fitness for flying duty under FAA Second Class medical standards. Those who meet these standards will normally be medically cleared for flying Army aircraft (using DA Form 4186 (Medical Recommendation for Flying Duty)) (see para 10-26*j*). Those who are issued FAA Second Class medical certificates by the FAA on the basis of demonstrated ability (waiver) will not be granted local medical clearance to fly Army aircraft if they have an established medical history or clinical diagnosis of any of the following conditions:

(a) *A character or behavior disorder that is severe enough to have repeatedly manifested itself by overt acts.*

(b) *A psychotic disorder.*

(c) *Chronic alcoholism.*

(d) *Drug addiction.*

(e) *Epilepsy.*

(f) *Disturbance of consciousness without satisfactory explanation of the cause.*

(g) *Myocardial infarction.*

(h) *Angina pectoris or other evidence of coronary disease.*

(i) *Diabetes requiring insulin or oral hypoglycemics.*

(j) *Treatment with antihistamine, narcotic, barbiturate, mood-ameliorating,*

tranquilizing, motion sickness, steroid, antihypertensive, or ataraxic drugs.

Pilots with the above conditions, or other conditions which are disqualifying, but who have a statement of demonstrated ability (waiver) from the FAA may in some cases be granted local medical clearance to fly Army aircraft upon written approval by the Cdr, USAAMC. Such approval may contain limitations, such as clearance to fly Army aircraft only with another fully qualified pilot or with a student pilot of demonstrated ability for safe solo flight in that aircraft. (See also para 10-26k, Waivers.)

(3) In addition, the following provisions apply to all civilian pilots:

(a) *Maximum allowable body weight and size* will be that which does not exceed seat, restraint system, or aircraft gross weight design limits; and which does not prevent normal functions required for safe and effective aircraft flight, to include interference with aircraft instruments and controls. Minimum body size, weight and physical strength will be that which allows safe and effective flight in Army aircraft to include proper function of ejection seats and other safety equipment. Local flight surgeons will prepare written reports and recommendations as required. Questionable cases will be referred to Cdr, USAAMC, for final determination.

(b) *Near and distant visual acuity* must be not less than 20/20 or correctable to 20/20. If uncorrected acuity is less than 20/20, corrective spectacles are required to be worn while flying. If the assigned duties of the individual include flying with vision related equipment (such as night vision goggles): distant visual acuity must be 20/20 uncorrected, or correctable to the acceptable level by any vision correction capability inherent to the device, or the device must be compatible with corrective spectacles.

(c) *Illegal use of any drug at any time* by DA civilian pilots and contract civilian pilots is medically unfitting for flying duty.

(d) Any civilian pilot employed by the Department of the Army or by a firm under contract to the Department of the Army, even though he or she holds a valid FAA Second Class Medical Certificate, may be denied medical clearance to fly Army aircraft if, in the opinion of the flight surgeon, *the individual poses an unacceptable risk* to him- or herself, to government property, or to other individuals. Questionable cases will be referred to Cdr,

USAAMC for final determination of medical fitness for flying duty.

(e) Any civilian pilot employed by the Army as a test pilot may be required by the Cdr, USAAMC to meet *special medical criteria* shown to be specifically related to safe and effective performance of his or her flying duties; subject to concurrence by the Office of Personnel Management.

c. *Medical consultation service.* A central Army Aviation Medicine Consultation Service (AMCS) and an Aeromedical Data Repository (ADR) are established at the US Army Aeromedical Center, Fort Rucker, AL 36362-5333. Consultation services are available to unit flight surgeons, command surgeons and the CG, US Army Health Service Command. Normally, requests for consultation by surgeons of higher headquarters will be initiated through unit flight surgeons to facilitate availability of essential medical records and related data. Medical consultation will not be requested by individual aviators nor by aviation unit commanders.

(1) Any individual on flying status may be referred for aviation medicine consultation by proper medical authority.

(2) An individual who is suspended from flying for medical reasons can only be referred to the AMCS by an authority equal to or higher than the one who suspended him or her.

(3) Army Reserve and Army National Guard personnel not on active duty may be referred through the Army area commander or Chief, National Guard Bureau, as appropriate.

(4) Non-US Army aviation personnel may be referred to the AMCS with prior approval of the CG, US Army Health Services Command.

(5) Requests for aviation medicine consultation will be forwarded direct to Cdr, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333.

(6) The Cdr, USAAMC, may utilize or authorize utilization of the Aeromedical consultation services of the US Navy and US Air Force, with the approval of appropriate medical authority of those agencies.

(7) The ADR will be used to assess the adequacy of existing aeromedical fitness standards through an epidemiological study of medical qualifications of the population group and to form the basis of proposed changes to standards. The ADR mission will be conducted in coordination with the US Army Aeromedical Research Laboratory.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

4-4. Abdomen and Gastrointestinal System

The causes of medical unfitness for flying duty in Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-3, plus the following:

a. *Enlargement of liver*, except when liver function tests are normal with no history of jaundice (other than during the neonatal period or associated with viral hepatitis), and the condition does not appear to be caused by active disease.

b. *Functional bowel distress syndrome* (irritable colon), megacolon, diverticulitis, regional enteritis, ulcerative colitis or history thereof.

c. *Hernia*.

(1) *Any variety*, other than small asymptomatic umbilical.

(2) *Classes 1 and 1A*, operation for hernia within the preceding 60 days. *Classes 2 and 3*, operation for hernia within the preceding 30 days.

d. *History of bowel resection for any cause except—*

(1) *Appendectomy*.

(2) *Intussusception* in childhood or infancy.

e. *Any other operations for relief of intestinal adhesions or intussusception*. Pylorotomy in infancy,

without complications at present will not, per se, be cause for rejection.

f. *Ulcer*.

(1) *Classes 1 and 1A*. See paragraph 2-3b.

(2) *Classes 2 and 3*. Until reviewed and found fit by the Cdr, USAMMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333.

g. *Cholecystectomy*.

(1) *Classes 1 and 1A*. Cholecystectomy within the preceding 90 days, or sequelae of cholecystectomy such as post-operative stricture of the common bile duct, reforming of stones in the hepatic or common bile ducts, incisional hernia, symptoms of post-cholecystectomy syndrome, or abnormal liver functions.

(2) *Classes 2 and 3*. Cholecystectomy within the preceding 60 days or sequelae of cholecystectomy such as those in paragraph 4-4g(1) above.

h. *Abdominal fistula or sinus*.

i. *Cholelithiasis*.

j. *Hemorrhage from the upper gastrointestinal tract* or history thereof, until reviewed and found fit by the Cdr, USAAMC.

Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

★ 4-5. Blood and Blood-Forming Tissue Diseases

The causes of medical unfitness for flying duty

Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-4.

Section IV. DENTAL

4-6. Dental

The causes of medical unfitness for flying duty

Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-5.

Section V. EARS AND HEARING

4-7. Ears

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-6, plus the following:

a. *Abnormal labyrinthine function* when determined by appropriate tests.

b. *Any infectious process of the ear*, except mild asymptomatic external otitis, until completely healed.

c. *Deformities of the pinna* if associated with tenderness which may be distracting when constant

pressure is extended as from wearing protective headgear.

d. *History of attacks of vertigo* with or without nausea, vomiting, deafness or tinnitus.

e. *Occlusion of either eustachian tube or limited motility of either tympanic membrane*.

f. *Post auricular fistula*.

g. *Unexplained recurrent or persistent tinnitus*.

h. *Radical mastoidectomy*.

i. *Simple mastoidectomy and modified radical mastoidectomy* until recovery is complete and the ear is functionally normal.

j. Tympanoplasty.

(1) *Classes 1 and 1A.* Tympanoplasty, until completely healed with acceptable hearing and good motility, as documented by current ENT evaluation and contingent upon review by Cdr, USAAMC.

(2) *Classes 2 and 3.* Tympanoplasty, until completely healed with acceptable hearing (app^{II}) and good motility.

*k. Cholesteatoma or history thereof.**l. Classes 1 and 1A. Otosclerosis.**m. Any surgical procedure in the middle ear*

which includes fenestration of the oval window, stapedectomy, fenestration of the horizontal semicircular canal, the use of any prosthesis or graft, reconstruction of the stapes with any prosthesis, or any endolymphatic shunting procedure.

4-8. Hearing

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are—Hearing loss in decibels greater than shown in table 2, appendix II.

Section VI. ENDOCRINE AND METABOLIC DISEASES**4-9. Endocrine and Metabolic Diseases**

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-8, plus the following:

*a. Hypothyroidism, hyperthyroidism, or history thereof.**b. Hyperuricemia.**c. Hypoglycemia or history thereof.***Section VII. EXTREMITIES****4-10. Extremities**

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in para-

graphs 2-9, 2-10, 2-11, and 4-23 plus dimensions, strength, endurance or limitation of motion which might compromise flying safety.

Section VIII. EYES AND VISION**4-11. Eyes**

The causes of medical unfitness for flying Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-12, plus the following:

a. Asthenopia of any degree including convergence insufficiency.*b. Chorioretinitis* or substantiated history thereof including evidence of presumed ocular histoplasmosis syndrome.*c. Coloboma* of the choroid or iris.*d. Epiphora.**e. Inflammation of the uveal tract;* acute, chronic, or recurrent or history thereof, including anterior uveitis, peripheral uveitis or pars plantis, and posterior uveitis.*f. Pterygium* which encroaches on the cornea more than 1 mm or is progressive as evidenced by marked vascularity or a thick elevated head.*g. Trachoma* unless healed without cicatrices.*h. Optic or retrobulbar neuritis* or history thereof.*i. Central serous retinopathy* or history thereof.*j. Pseudophakia* (intraocular lens implant).*k. Congenital optic nerve pit.**l. Retinal holes or tears* or history thereof.*m. Optic nerve drusen or hyaline bodies of the optic nerve.**n. Herpetic corneal ulcer or keratitis;* acute, chronic, recurrent, or history thereof.*o. Xerophthalmia.**p. Elevated intraocular pressure.*(1) *Classes 1 and 1A.*

(a) *Glaucoma* as evidenced by applanation tension 30 mm Hg or higher, or secondary changes in the optic disc or visual field associated with glaucoma.

(b) *Preglaucoma or intraocular hypertension* as evidenced by two or more determinations of 22 mm Hg or higher or a persistent difference of 4 or more mm Hg tension between the two eyes, when confirmed by applanation tonometry.

(2) *Classes 2 and 3.*(a) *Glaucoma.*

(b) *Preglaucoma* until reviewed by the Cdr, USAAMC.

q. History of extraocular muscle surgery until reviewed by Cdr, USAAMC.

r. Full or part time use of contact lenses including orthokeratology (to correct refractive error), or

history thereof, until reviewed by Cdr, USAAMC.

s. *History of refractive keratoplasty* including anterior or radial keratotomy.

t. *Visual or acephalic migraine*, or history thereof.

4-12. Vision

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are—

a. Class 1.

(1) *Color vision.*

(a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set unless applicant passes the Farnsworth Lantern (FALANT) (USN) test, or

(b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set unless FALANT is passed.

(c) When administered in lieu of (a) or (b) above, failure to pass the FALANT, with more than 2 errors in the reading of 18, or more than 3 in a reading of 27 test lights.

(2) *Depth perception.*

(a) Any error in lines B, C, or D when using the Armed Forces Vision Tester.

(b) Any error with Verhoeff Stereometer when used in lieu of (a) above or when examinee fails (a).

(3) *Distant visual acuity*, uncorrected, less than 20/20 in each eye.

(4) *Near visual acuity*, uncorrected, less than 20/20 (J-1) in each eye.

(5) *Field of vision.*

(a) Any demonstrable scotoma, other than physiologic or anatomic.

(b) Contraction of the field for form of 15° or more in any meridian.

(6) *History of night blindness*, confirmed by failure to pass night vision test.

(7) *Ocular motility.*

(a) Any diplopia or suppression in the Red Lens Test which develops within 20 inches from the center of the screen in any of the 6 cardinal directions.

(b) Esophoria greater than 8 prism diopters.

(c) Exophoria greater than 8 prism diopters.

(d) Hyperphoria greater than 1 prism diopter.

(e) Heterotropia, any degree.

(f) Near point of convergence (NPC) greater than 70 mm.

(8) *Power of accommodation* or less than minimum for age as shown in appendix V.

(9) *Refractive error.*

(a) Astigmatism in excess of ± 0.75 diopter.

(b) Hyperopia in excess of 1.75 diopter in any meridian.

(c) Myopia in excess of 0.25 diopter in any meridian.

★(d) Refractive error corrected by orthokeratology or keratorefractive surgery.

b. *Class 1A.* Same as Class 1 except as listed below:

(1) *Distant visual acuity.* Uncorrected less than 20/50 in each eye or not correctable with spectacle lenses to 20/20 in each eye.

(2) *Near visual acuity.*

(a) *Individuals under age 35.* Uncorrected, less than 20/20 (J-1) in each eye.

(b) *Individuals age 35 or over.* Uncorrected, less than 20/50 in each eye or not correctable with spectacle lenses to 20/20 in each eye.

(3) *Refractive error.*

(a) Astigmatism greater than ± 0.75 diopter.

(b) Hyperopia.

1. *Individuals under age 35.* Greater than 1.75 diopter in any meridian.

2. *Individuals age 35 or over.* Greater than 2.00 diopters in any meridian.

(c) Myopia greater than 0.75 diopter in any meridian.

(d) Refractive error corrected by orthokeratology or radial keratotomy.

c. *Class 2.* Same as Class 1 except as listed below:

(1) *Distant visual acuity.* Uncorrected less than 20/100 in each eye (flight surgeons: 20/200) or not correctable with spectacle lenses to 20/20 in each eye.

(2) *Near visual acuity.* Uncorrected less than 20/100 in each eye (flight surgeons: 20/200) correctable with spectacle lenses to at least 20/20 in each eye.

(3) *Field of vision.* Scotoma, other than physiological, anatomical, or spectacle related, unless the pathologic process is healed and will in no way interfere with flying efficiency or the well-being of the individual.

(4) *Ocular motility.*

(a) Hyperphoria greater than 1.5 prism diopters.

(b) Failure of the Red Lens Test (suppression or diplopia within 20 inches from the center of the

screen in any of the 6 cardinal directions) until a complete evaluation performed by a qualified ophthalmologist has been forwarded to the Cdr, USAAMC, who will determine fitness for flying duty.

(5) *Refractive error* of such magnitude that the individual cannot be fitted with aviation spectacles.

d. *Class 3.*

(1) *Color vision.* Same as Class 1, paragraph 4-12a(1) above.

(2) *Distant visual acuity.* Uncorrected less than 20/200 in each eye, not correctable to 20/20 in each eye with spectacle lenses.

(3) *Near visual acuity, field of vision, depth perception, refractive error:* same as Class 2.

Section IX. GENITOURINARY SYSTEM

4-13. Genitourinary System

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraphs 2-14 and 2-15, plus the following:

a. *Classes 1, 1A, 2 and 3.* A history of urinary tract stone formation until reviewed and found fit by Cdr, USAAMC, Fort Rucker, AL. Evaluation will follow guidance provided by Cdr, USAAMC, to include:

- (1) Excretory urography.
- (2) Renal function testing.
- (3) Specified metabolic studies.

b. *Pregnancy and postpartum.*

(1) *Classes 1, 1A, 2 and 3 for entry into training.* For aviation duty, all classes; and for 6 weeks after termination of pregnancy by any means or un-

til all complications and sequelae have resolved, whichever is longer.

(2) *Class 2A, ATC* if accompanied by signs or symptoms which, in the opinion of the flight surgeon and/or obstetrician, pose any significant risk to the health and well-being of the member or the fetus; or which, through performance degradation or potential degradation, results or may result in any compromise of aviation safety.

c. *Menstrual cycle changes, classes 2, 2A and 3,* while signs or symptoms are present which result in increased risk in the aviation environment.

d. *Significant hematuria or history thereof,* from any cause, unless remedial and corrective procedures have been successfully accomplished.

e. *Hyposthenuria.*

Section X. HEAD AND NECK

(See also para 4-23)

4-14. Head and Neck

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraphs 2-16, 2-17 and 4-23 plus the following:

a. *A history of subarachnoid hemorrhage.*

b. *Cervical lymph node involvement of malignant origin.*

c. *Loss of bony substance of skull.*

d. *Persistent neuralgia, tic douloureux; or facial paralysis.*

Section XI. HEART AND VASCULAR SYSTEM

4-15. Heart and Vascular System

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraphs 2-18, 2-19 and 2-20 plus the following:

a. *Abnormal slowing of the pulse, fall in blood pressure, or alteration in cerebral circulation* resulting in fainting or syncope because of digital pressure on either carotid sinus (abnormal carotid sinus reflex).

b. *A substantiated history of paroxysmal supraventricular arrhythmias,* such as paroxysmal atrioventricular nodal reentry tachycardia, nonparoxys-

mal junctional tachycardia, atrial flutter, or atrial fibrillation unless for Class 2 or 3 and complete evaluation, including intracardiac electrophysiologic study, fails to demonstrate a pathophysiologic substrate for recurrent arrhythmias.

c. *A history of ventricular tachycardia.*

d. *A history of rheumatic fever* or documented manifestations diagnostic of rheumatic fever within the preceding 5 years. Strict historical documentation of the Jones criteria is required, including two major criteria (carditis, chorea, erythema marginatum, migratory polyarthrits, and subcutaneous

nodules) and bacteriologic or immunologic evidence of Group A beta hemolytic streptococcal pharyngitis within 3 weeks of the clinical syndrome. Evidence of rheumatic valvulitis at any time in the clinical course is disqualifying under chapter 2-18a.

e. Cardiac enlargement or dilated cardiomyopathy as determined by complete cardiac evaluation, including M-mode or two-dimensional echocardiography.

f. Blood pressure. (Certain aviation personnel who exceed these standards may be temporarily allowed to continue flying duties in accordance with policy letters issued by the Cdr, USAAMC.)

(1) *Preponderant systolic* less than 90 mm Hg or greater than 140 mm Hg, regardless of age.

(2) *Preponderant diastolic* less than 60 mm Hg

or greater than 90 mm Hg, regardless of age.

g. Unsatisfactory orthostatic tolerance test.

h. Electrocardiographic.

★(1) *Borderline ECG findings* (Classes 1, 1A and 2) until reviewed by the Cdr, USAAMC. Review and final determination is made locally on Class 3; assistance will be provided by the Cdr, USAAMC, upon request. (Cdr, USAAMC ATTN: HSYX-AER, Fort Rucker, AL 36362-5333.)

(2) *Left bundle branch block.*

(3) *Persistent premature contractions*, except in rated personnel when unassociated with significant heart disease or documented tachycardia.

(4) *Right bundle branch block* unless cardiac evaluation reveals that the patient is free of cardiac disease and that the block is presumably congenital.

★(5) *Short P-R interval and prolonged QRS interval (Wolff-Parkinson-White syndrome) or other pre-excitation syndrome predisposing to paroxysmal arrhythmias.* In asymptomatic patients requiring Class 2 or Class 3 examinations, a complete cardiac evaluation, including ECGs, will be forwarded to the Cdr, USAAMC.

★i. *Pericarditis*, history of finding thereof, except for a history of a single episode of acute idiopathic or viral pericarditis with no residuals at least 6 months after discontinuing all medications. ECGs must have returned to normal. Complete cardiac evaluation including ECGs will be forwarded to the Cdr, USAAMC.

★j. *Mitral valve prolapse.* Auscultatory or echocardiographic evidence of late systolic or holosystolic prolapse is disqualifying for Classes 1 and 1A. If symptoms are present, any evidence of mitral valve prolapse is also disqualifying for Classes 2 and 3 until reviewed and found fit by Cdr, USAAMC.

★k. *Hypertrophic cardiomyopathy.* Clinical or echocardiographic evidence of hypertrophic cardiomyopathy (obstructive or non-obstructive) is disqualifying for Classes 1, 1A, 2 and 3 examinations.

★l. *Coronary artery disease.* Any clinical or angiographic evidence of coronary artery disease is disqualifying for all classes of flight physicals.

Section XII. HEIGHT, WEIGHT, AND BODY BUILD

4-16. Height

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are—

★a. *Classes 1, 1A and 2.* Height below 64 inches or over 76 inches unless other anthropometric criteria (sitting height, leg length, and function arm reach) established by HQDA (DASG-PSP), Washington, DC 20310, are met. This does not apply to civilian pilots; see paragraph 4-3b(3).

★b. *Class 3.* Height below 64 inches or over 76 inches.

★4-17. Weight

a. The causes of medical unfitness of military personnel for flying duty Classes 1, 1A, 2 and 3 are body weight less than initial procurement standards prescribed in appendix III, or body weight and composition that exceed the limits prescribed by AR 600-9.

b. Body composition in excess of limits prescribed by AR 600-9 is not disqualifying for Class 2A ATC duties.

c. Military personnel exceeding the limits prescribed in the Weight for Height Table

(Screening Table Weight) in AR 600-9 will have their maximum allowable weight recorded annually on SF 88 (Report of Medical Examination) or DA Form 4497-R (Interim Medical Examination) at the time of their flying duty medical examination. Additionally, composition (percent body fat) will be recorded upon entry into each new age category for these personnel.

d. See paragraph 4-3b(3) for civilian pilots.

4-18. Body Build

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-23, plus the following:

★*Obesity.* Even though the individual's weight or body composition is within the limits prescribed by AR 600-9, he or she will be found medically unfit if the examiner considers that his or her weight and/or associated conditions in relationship to the bony structure, musculature and/or total body fat content would adversely affect flying safety or endanger the individual's well-being if permitted to continue in flying status. See paragraph 4-3b(3) for civilian pilots.

Section XIII. LUNGS AND CHEST WALL

4-19. Lung and Chest Wall

The causes of medical unfitness for flying duty

Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-24, 2-25, 2-26, and 4-27g, plus the following.

a. *Coccidioidomycosis* unless healed without evidence of cavitation.

b. *Lobectomy*.

(1) *Classes 1 and 1A*. Lobectomy, per se.

(2) *Classes 2 and 3*. Lobectomy:

(a) Within the preceding 6 months.

(b) With a value of less than 80 percent of predicted vital capacity (app VI).

(c) With a value of less than 75 percent of exhaled predicted vital capacity (app VI).

(d) With a value of less than 80 percent of the predicted maximum breathing capacity (app VI).

(e) With any other residual or complication of lobectomy which might endanger the individual's health and well-being or compromise flying safety.

c. *Pneumothorax, spontaneous*.

(1) *Classes 1 and 1A*. A history of spontaneous pneumothorax.

(2) *Classes 2 and 3*. Spontaneous pneumothorax except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung and normal pulmonary function, no additional

lung pathology or other contraindication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 12 months.

d. *Pulmonary tuberculosis and tuberculous pleurisy with effusion*.

(1) *Classes 1 and 1A*. Individuals taking prophylactic chemotherapy.

(2) *Classes 2 and 3*. During period of drug therapy or with impaired pulmonary function greater than outlined in b(2) above.

e. *Tuberculous pleurisy with effusion*.

(1) *Classes 1 and 1A*. Tuberculous pleurisy with effusion, per se.

(2) *Classes 2 and 3*. Tuberculous pleurisy with effusion until 12 months after cessation of therapy.

★f. *Presence of bullae* until reviewed and found fit by Cdr, USAAMC.

★g. *Bronchial asthma or recurrent bronchospastic conditions*, except for childhood asthma with a trustworthy history of freedom from symptoms of asthma or recurrent bronchospasm since the 12th birthday, until reviewed and found fit by the Cdr, USAAMC.

Section XIV. MOUTH, NOSE, PHARYNX, LARYNX, TRACHEA, ESOPHAGUS

4-20. Mouth

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-27, plus the following:

a. *Any infectious lesion* until recovery is complete and the part is functionally normal.

b. *Any congenital or acquired lesion* which interferes with the function of the mouth or throat.

★c. *Any defect in speech* which would prevent clear enunciation or otherwise interfere with clear and effective communication in the English language over a radio communication system (see app IX, item 72, and app X, for Reading Aloud Test).

d. *Recurrent calculi* of any salivary gland or duct.

4-21. Nose

The causes of medical unfitness for flying duty

Classes 1, 1A, 2 and 3 are the causes listed in paragraphs 2-28 and 4-27 plus the following:

a. *Acute coryza*.

b. *Allergic rhinitis*.

(1) *Classes 1 and 1A*. Any substantial history of allergic or vasomotor rhinitis, unless free of all symptoms since age 12.

(2) *Classes 2 and 3*. Allergic rhinitis unless mild in degree and considered unlikely to limit the examinee's flying activities.

c. *Anosmia, parosmia, and paresthesia*.

d. *Atrophic rhinitis*.

e. *Deviation of nasal septum or septal spurs* which result in 50 percent or more obstruction of either airway, or which interfere with drainage of the sinus on either side.

f. *Hypertrophic rhinitis* (unless mild and functionally asymptomatic).

★g. *Nasal polyps* or history thereof.

h. *Perforation of the nasal septum* unless small, asymptomatic, and the result of trauma.

i. Sinusitis:

(1) *Classes 1 and 1A.* Sinusitis of any degree, acute or chronic. If there is only X-ray evidence of chronic sinusitis and the history reveals the examinee to have been asymptomatic for 5 years, this X-ray finding alone will not be considered as rendering the individual medically unfit.

(2) *Classes 2 and 3.* Acute sinusitis of any degree; chronic sinusitis until reviewed and found fit by Cdr, USAAMC.

4-22. Pharynx, Larynx, Trachea, Esophagus

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraph 2-29, plus the following:

a. Any lesion of the nasopharynx causing nasal obstruction.

b. A history of recurrent hoarseness.

c. A history of recurrent aphonia or a single attack if the cause was such as to make subsequent attacks probable.

d. History of repeated hemorrhage from nasopharynx unless a benign lesion is identified and eradicated.

e. Occlusion of one or both eustachian tubes which prevents normal ventilation of the middle ear.

f. Tracheotomy occasioned by tuberculosis, angioneurotic edema, or tumor. Tracheotomy for other reasons will be cause for rejection until 3 months have elapsed without sequelae.

Section XV. NEUROLOGICAL DISORDERS

★(See also para 4-14)

4-23. Neurological Disorders

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-31 and 4-14, plus the following:

a. *Classes 1 and 1A.*

(1) History of unexplained syncope.

★(2) History of convulsive seizures, single, or multiple, of any type (grand mal, petit mal, focal, etc.) due to any causes; except that seizures associated with febrile illness before age 5 years may be acceptable if the electroencephalogram is normal.

★(3) History of any headache of the vascular, migraine, or cluster (Horton's cephalgia or histamine headache) type.

(4) History of new growth of the brain, spinal cord, or their coverings.

★(5) History of diagnostic or therapeutic craniotomy or any procedure involving penetration of the dura mater or the brain substance.

★(6) Any defect in the bony substance of the skull, regardless of cause.

★(7) Encephalitis, unless 6 years have elapsed since recovery, no sequelae or residuals have been present during the period beginning 6 months after complete recovery from the acute phase of the illness, and a current complete neurological evaluation is normal in all respects.

★(8) Meningitis, unless 1 year has elapsed since recovery, no residuals or sequelae have been present during the period beginning 1 month after complete recovery from the acute phase of the illness, and a current complete neurological evaluation is normal in all respects.

★(9) Any history of metabolic or toxic disturbances of the central nervous system until reviewed by Cdr, USAAMC, and found fit.

★(10) Any history of dysbarism (decompression sickness) with neurological involvement until reviewed by Cdr, USAAMC, and found fit.

★(11) Electroencephalographic abnormalities of any kind. Borderline or questionable tracings until reviewed by Cdr, USAAMC, and found fit.

★(12) Any history of narcolepsy, cataplexy or similar states.

★(13) Injury of one or more peripheral nerves, unless not expected to interfere with normal function or flying safety.

★(14) Any history of subarachnoid hemorrhage, embolism, vascular insufficiency, thrombosis, hemorrhage, arteriovenous malformation or aneurysm involving the central nervous system.

★(15) Personal or familial history of hereditary disturbances such as hepatolenticular de-

generation, neurofibromatosis, acute intermittent porphyria, or familial periodic paralysis. A strong family history of such syndromes indicating a hereditary component will be cause for disqualification even in the absence of current clinical symptoms or signs, since the onset of these illnesses may occur later in adult life.

★(16) Any evidence or history of *degenerative or demyelinating process* such as multiple sclerosis, dementia, or basal ganglia disease.

★(17) History of *head injury* associated with any of the following:

(a) Intracranial hemorrhage or hematoma (epidural, subdural or intracerebral) or subarachnoid hemorrhage.

(b) Any penetration of the dura mater or brain substance.

(c) Radiographic or other evidence of retained intracranial foreign bodies or bony fragments.

(d) Transient or persistent neurological deficits indicative of parenchymal central nervous system injury, such as hemiparesis or hemianopsia. Damage to one or more cranial nerves is not necessarily disqualifying unless it interferes with normal function in some practical manner.

(e) Persistent focal or diffuse abnormalities of the electroencephalogram reasonably assumed to be a result of the injury.

(f) Any skull fracture, linear or depressed, with or without dural penetration.

(g) Post-traumatic syndrome as manifested by personality changes, impairment of higher intellectual functions, anxiety, headache or disturbances of equilibrium.

1. Duration of symptoms for 48 hours or more.

2. Duration of symptoms more than 12 but less than 48 hours until at least 2 years have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

3. Duration of symptoms less than 12 hours until at least 6 months have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

(h) Amnesia (post-traumatic and retrograde, patchy or complete), delirium, disorientation, confusion or impairment of judgment or intellect.

1. Duration 48 hours or more.

2. Duration less than 48 hours, but more than 12 hours, until 2 years have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

3. Duration less than 12 hours, until 6 months have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

(i) Post-traumatic headaches.

1. Persistence of headaches for 14 days or more.

2. Persistence of headaches for more than 7 but less than 14 days, until at least 2 years have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

3. Persistence of headaches for less than 7 days, until at least 6 months have elapsed since the injury and a current complete neurological evaluation is normal in all respects.

(j) Cerebrospinal fluid rhinorrhea or otorrhea, leptomeningeal cyst, arachnoid cyst, brain abscess or arteriovenous fistula.

(k) Loss of consciousness.

1. Unconsciousness for 2 hours or more.

2. Unconsciousness less than 2 hours, but more than 15 minutes, until 2 years have elapsed since the injury and complete neurological evaluation is normal in all respects.

3. Unconsciousness for less than 15 minutes, until 6 months have elapsed since the injury and complete neurological evaluation is normal in all respects.

★b. *Classes 2 and 3.* Same as a except as modified below:

(1) *Fainting or syncope* of any type due to any cause until appropriate consultations have been accomplished and the case reviewed by Cdr, USAAMC.

(2) *All acute infections of the central nervous system* (meningitis, encephalitis, etc.) until—

(a) Active disease is arrested.

(b) Further sequelae are not expected.

(c) Residuals, if any, are resolved.

(d) Case has been reviewed by Cdr, USAAMC.

(3) *Electroencephalographic abnormalities* in otherwise apparently healthy individuals are not necessarily disqualifying with the exception of—

- (a) Spike-wave complexes.
- (b) Spikes or sharp waves.
- (c) Other abnormalities as determined by

Cdr, USAAMC.

(4) *Head injury.*

(a) Head injury resulting in the following will be cause for permanent disqualification for flying duty:

1. All causes listed in paragraph 4-23a(17)(a) through (e).
2. Depressed skull fracture with or without dural penetration.
3. Linear skull fracture with unconsciousness for more than 2 hours.
4. Post-traumatic syndrome as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches or disturbances of equilibrium which does not resolve within 1 month after the injury.
5. Unconsciousness exceeding 24 hours.
6. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.
7. Permanent cranial nerve deficit, until reviewed by Cdr, USAAMC.

(b) Head injury associated with any of the complications below will be cause for removal from flying duty for at least 2 years. Electroencephalograms will be obtained as soon after the injury as possible and at 1-year intervals until completely normal or until the examinee is determined to be permanently disqualified in accordance with paragraph 4-23b(4)(a). Prior to return to flying status, a current complete neurological evaluation by a qualified neurologist or neurosurgeon, including skull X-rays, electroencephalogram and neuropsychological test battery (e.g., Halstead-Reitan), will be accomplished and the case reviewed by the Cdr, USAAMC.

1. Linear or basilar skull fracture with loss of consciousness for more than 15 minutes but less than 2 hours.

2. Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches or disturbances of equilibrium, which persists

for more than 2 weeks but resolves within 1 month of injury.

3. Amnesia (post-traumatic and retrograde, patchy or complete), delirium, disorientation or impairment of judgment which exceeds 48 hours.

4. Unconsciousness for a period greater than 2 but less than 24 hours.

(c) Head injury associated with any of the following will be cause for removal from flying duties for at least 3 months. Complete evaluation by a qualified neurologist or neurosurgeon is required just prior to return to flying duty. An electroencephalogram will be obtained as soon after the injury as possible and another at the time of consideration for return to flying duty. If an abnormality is found in any portion of the evaluation (neurologic examination, skull X-rays, electroencephalogram or neuropsychological test battery), the examinee will not be cleared for return to flight duties but will be referred back to the consultant at appropriate intervals for reevaluation until cleared or determined to be permanently disqualified in accordance with paragraph 4-23b(4)(a).

1. Linear or basilar skull fracture with loss of consciousness for less than 15 minutes. This diagnosis does not have to be confirmed by X-rays, but may be based on clinical findings.

2. Post-traumatic syndrome, as manifested by changes in personality, impairment of higher intellectual functions, anxiety, headaches or disturbances of equilibrium, which persists for more than 48 hours, but resolving within 14 days of the injury.

3. Post-traumatic headaches alone which persist more than 14 days after the injury, but resolve within 1 month.

4. Amnesia (post-traumatic and retrograde, patchy or complete), delirium or disorientation which lasts less than 48 but more than 12 hours after injury.

5. Confusion lasting more than 48 hours.

6. Unconsciousness for more than 15 minutes but less than 2 hours.

7. Cerebrospinal fluid rhinorrhea or otorrhea which clears within 7 days of injury, provided there is no evidence of cranial nerve palsy.

(d) Head injury associated with any of the following will be cause for removal from flying duty for at least 4 weeks. Return to flying duty will be contingent upon a normal neurological evaluation by a qualified neurologist or neurosurgeon, including skull X-rays, electroencephalogram and neuropsychological test battery, at the end of that time.

1. Post-traumatic syndrome, as manifested by changes in personality, impairment of

higher intellectual function or anxiety, which resolve within 48 hours of injury.

2. Post-traumatic headaches alone, which resolve within 14 days of injury.

3. Amnesia (post-traumatic and retrograde, patchy or complete), delirium, disorientation for less than 12 hours.

4. Confusion lasting less than 48 hours.

5. Unconsciousness lasting less than 15 minutes.

Table 4-1. Neurology

Complaint	Class 1, 1A			Class 2, 3			
	Permanent disqual.	2-yr wait	6-mo wait	Permanent disqual.	2-yr disqual.	3-mo disqual.	4-wk disqual.
Syncope	Unexplained	.....	.....	Until Rev	.....	.....	.....
Seizure	Any	.....	.....	Same	.....	.....	.....
Vascular Headache	Any	.....	.....	Same	.....	.....	.....
New Growth	Any	.....	.....	Same	.....	.....	.....
Craniotomy	Any	.....	.....	Same	.....	.....	.....
Bony Defect	Any	.....	.....	Same	.....	.....	.....
Encephalitis	6 yrs	.....	.....	Until Rev	.....	.....	.....
Meningitis	1 yr	.....	.....	Until Rev	.....	.....	.....
Metabolic Disorder	Until Rev	.....	.....	Same	.....	.....	.....
CNS Bends	Until Rev	.....	.....	Same	.....	.....	.....
EEG Abnormality	Until Rev	.....	.....	Specified	.....	.....	.....
Narcolepsy	Any	.....	.....	Same	.....	.....	.....
Peripheral							
Nerve Injury	Any	.....	.....	Same	.....	.....	.....
Vascular Problems	Any	.....	.....	Same	.....	.....	.....
Familial Disease	Any	.....	.....	Same	.....	.....	.....
Degenerative Disease	Any	.....	.....	Same	.....	.....	.....
Head Injury							
Bleeding	Any	.....	.....	Same	.....	.....	.....
Penetrated Dura	Any	.....	.....	Same	.....	.....	.....
Fragments	Any	.....	.....	Same	.....	.....	.....
CNS Defect	Any	.....	.....	Same	.....	.....	.....
EEG Abnormality	Due to Injury	.....	.....	Same	.....	.....	.....
Depressed Fracture	Any	.....	.....	Any	.....	.....	.....
Basilar Fracture	Any	.....	.....	LOC>2h	LOC 15m-2h	LOC<15m	.....
Linear Fracture	Any	.....	.....	LOC>2h	LOC 15m-2h	LOC<15m	.....
Post Trauma							
Syndrome	>48h	12-48h	<12h	>1 mo	2 wk-1 mo	48h-14d	<48h
Headaches only	>14d	7-14d	<7d	>1 mo	.....	>14d	<14d
Amnesia	>48h	12-48h	<12h	.....	>48h	12-48h	<12h
Confusion	>48h	12-48h	<12h	.....	.....	>48h	<48h
Loss of Consciousness	>2h	15m-2h	<15m	>24h	2-24h	15m-2h	<15m
CSF Leak	Any	.....	.....	>7d	.....	<7d	.....
Cranial N Palsy	Func Sig	.....	.....	Until Rev	.....	.....	.....

Section XVI. MENTAL DISORDERS

4-24. Mental Disorders

The causes of medical unfitness for flying duty Classes 1, 1A, 2 and 3 are the causes listed in paragraphs 2-30, 2-31, 2-32, 2-33, 2-34, and 2-35, except as modified below.

a. Any psychotic episode evidenced by impairment in reality testing, to include transient disorders, from any cause except transient delirium secondary to toxic or infectious processes before age 12.

b. Any history of an affective disorder fitting the diagnostic criteria outlined in DSM III to include major affective disorders, cyclothymic disorder, dysthymic disorder, and atypical affective disorders.

c. Any history of anxiety disorder, somatoform disorder, or dissociative (including but not limited to those disorders previously described as neurotic) fitting the diagnostic criteria outlined in DSM III. Additionally, the presence or history of any phobias or severe or prolonged anxiety episodes, after age 12, even if they do not meet the fully diagnostic criteria of DSM III.

d. Any history of an episode that fits the criteria for any of the diagnoses listed in DSM III chapters on factitious disorders and disorders of impulse control not listed elsewhere.

e. Any history of pervasive or specific developmental disorders usually first seen in childhood as outlined in DSM III. Stuttering, sleep-walking and

sleep terror disorders are not disqualifying if not occurring after age 12.

f. Any suspected *personality or behavior disorder*. Personality traits insufficient to meet full DSM III criteria for personality disorder diagnosis that potentially affect flying duty may be cause for an unsatisfactory ARMA.

g. A history of any *adjustment disorder* that meets the diagnostic criteria of DSM III.

h. *Excessive use of alcohol* or history thereof which has interfered with the performance of duty, physical health, social relationship or family relationship.

(1) Such individuals, as well as those medically unfit under paragraph 2-37, can be returned to flying duties only in accordance with paragraph 10-26i (i.e., with waiver).

(2) Individuals under Class 2 or 3 continuance standards with mild or minimal alcohol-related problems which have not interfered with the performance of duty and who recognize that alcohol is or may become a problem for them and voluntarily enter and successfully complete a rehabilitation program in accordance with AR 600-85 (i.e., a military program) may be returned to flying duty by their commander, without a waiver, if rehabilitation is completed before the time prescribed in AR 600-105 for temporary suspension and a favorable recommendation is received from the alcohol rehabilitation program clinical director and the local flight surgeon. The flight surgeon may recommend to the commander the limitation of dual status for an initial period of time, if deemed appropriate. The individual must meet all other medical fitness standards for flying duty, to include provisions of AR 40-8, pertaining to systemic medication (must not be on antabuse therapy). He or she must also be free of significant underlying psychologic or psychiatric disorder(s), have no evidence of lasting or residual health impairment (hepatic, gastroenteric or other sequelae), and be experiencing no significant social or family conflict.

(a) The flight surgeon will evaluate the individual not less than every 2 months for at least 1 year after return to flying duty to determine his continued medical fitness for such duty. One year after return to flying duty, the flight surgeon will submit an Aeromedical Summary to the Cdr, USAAMC. The Aeromedical Summary will be used by the Cdr, USAAMC, to determine overall adequacy and success of rehabilitation and locally ap-

proved return to flying duty. The flight surgeon will also evaluate the individual at least once approximately 18 months and 24 months after return to flying duty and then annually in conjunction with the annual medical examination for flying duty. The annual and interim reports of medical examination on aviation personnel returned to flying status in accordance with this paragraph (i.e., without waiver) will contain an entry (item 73, SF 88 (Report of Medical Examination), or item 14, DA Form 4497-R (Interim Medical Examination—Aviation. Free Fall Parachuting & Marine (SCUBA) Diving Personnel)) reflecting dates of the rehabilitation program and date of return to flying duties. A return to flying status without a waiver can be accomplished only one time; a waiver is required if the individual needs an additional subsequent rehabilitation program. The 18- and 24-month evaluation(s) will be recorded as an Aeromedical Summary and forwarded to the Cdr, USAAMC.

(b) All Aeromedical Summaries pertaining to the rehabilitated individual will include, in the narrative or attached thereto, narrative reports with recommendations from the Aviation Unit Commander and the ADAPCP Clinical Director.

(c) Active duty personnel and Reserve Component personnel on extended active duty must meet the above requirements to be returned to flying duty without a waiver. Reserve Component personnel not on active duty, who otherwise meet the above requirements, may be returned to flying duty following rehabilitation in a nonmilitary rehabilitation program if they otherwise meet the criteria of AR 600-85.

★i. *Drug abuse or misuse.* Paragraph 2-35 will apply. A history of illicit use of any psychoactive substance not disqualifying under paragraph 2-35 must be reviewed by the Cdr, USAAMC. A history of experimental or infrequent use of marijuana is not medically unfitting for acceptance for aviation training. Illegal use of any drug or psychoactive substance of abuse, other than alcohol, at any time after acceptance for or during aviation training or duty is medically unfitting for further flying duty.

j. History of *suicide attempt or gesture* at any time.

k. *Insomnia*, severe or prolonged.

l. *Fear of flying* manifested as a psychiatric or somatic symptom (refusal to fly or conscious fear of flying; i.e., conscious choice not to fly, is an admin-

istrative problem).

m. Vasomotor instability.

n. Abnormal emotional responses to situations of stress (either combat or noncombat) when, in the

opinion of the examiner, such reaction will interfere with the efficient and safe performance of an individual's flying duties.

Section XVII. SKIN AND CELLULAR TISSUES

4-25. Skin and Cellular Tissues

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in para-

graph 2-36, plus any condition which interferes with the use of aviation clothing and equipment.

Section XVIII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

4-26. Spine, Scapulae, Ribs, and Sacroiliac Joints

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-37 and 2-38 plus the following:

a. Classes 1 and 1A.

(1) A history of *disabling episode of back pains*, especially when associated with significant objective findings.

(2) *Fracture or dislocation of the vertebrae or*

history thereof.

(3) *Lateral deviation of the spine from the normal midline* of more than 1 inch (scoliosis), even if asymptomatic.

(4) *Cervical arthritis or cervical disc disease.*

b. Classes 2 and 3. Any of the conditions listed in *a* above of such a nature or degree as to compromise health or flying safety, plus the following:

(1) *Fracture or dislocation of the cervical spine or history thereof.*

(2) *History of laminectomy or spinal fusion.*

Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

4-27. Systemic Diseases and Miscellaneous Conditions and Defects

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraphs 2-39 and 2-40, except as modified below.

a. Sarcoidosis.

(1) *Classes 1, 1A and 3.* A history of sarcoidosis, even if in remission.

(2) *Class 2.* Sarcoidosis, even if in remission, until evaluated and found fit by Cdr, USAAMC.

b. Tuberculosis. See paragraphs 4-19*d* and *e*.

c. Allergic manifestations. See paragraphs 2-26, 2-39, 4-19 and 4-21.

d. Malaria.

(1) *Classes 1 and 1A.* A history of malaria unless—

(a) There have been no symptoms for at least 6 months during which time no antimalarial drugs have been taken.

(b) The red blood cells are normal in number and structure, and the blood hemoglobin is at least 12 grams percent.

(c) A thick smear (which must be done if the disease occurred within 1 year of the examination)

is negative for parasites.

(2) *Classes 2, 2A, and 3.* A history of malaria unless adequate therapy in accordance with existing directives has been completed. The duration of removal from flying or air traffic control duties is an individual problem and will vary with the type of malaria, the severity of the infection and the response to treatment. However, personnel may not fly or control air traffic unless they have been afebrile for 7 days, their blood cells are normal in number and structure, their blood hemoglobin is at least 12 grams percent and a thick smear (which must be done if the disease occurred within 1 year of the examination) is negative for parasites. A thick smear and a medical evaluation will be performed every 2 weeks for at least 3 months after all antimalarial therapy has been stopped.

e. Motion sickness. *Classes 1 and 1A.*

(1) History of *motion sickness*, other than isolated instances without emotional involvement.

(2) History of previous elimination from flight training at any time due to *airsickness*.

f. Drugs, beverage alcohol, immunizations, blood donations, diving, and other exogenous factors.

Classes 2 and 3. In accordance with AR 40-8. Oral contraceptives and low dose tetracyclines (other than minocycline) are not unfitting for Class 1, Class 1A, initial Class 2 or initial Class 3; provided however, that in the case of oral contraceptives the medication must not have been prescribed for an underlying pathologic condition which is disqualifying; the applicant must have been on the specific drug for at least three cycles; and must be free of side effects at the time of examination for both oral contraceptives and low dose tetracycline; SF 93 (Report of Medical History) must show the type and dosage of drug, duration of treatment, and presence or absence of side effects.

g. Exposure to riot control agents. Classes 2 and 3. Following unprotected exposure, for 2 hours or until all symptoms of eye and/or respiratory tract irritation disappear, whichever is longer, and until all risk of secondary exposure from contaminated

skin, clothing, equipment or aircraft structures has been eliminated through cleansing, decontamination, change of clothing and equipment, or other measures. In no case will both the pilot and copilot be deliberately exposed at the same time unless one is wearing adequate protective equipment.

h. Other diseases and conditions. Classes 1, 1A, 2, 2A, and 3. Other diseases and conditions which, based upon sound aeromedical principles, may, in any way, interfere with the individual's health and well-being or compromise flying safety; or which may progress to a degree which may compromise health, well-being or flying safety. This determination will be made initially, and recommendations made to the individual's commander, by the local flight surgeon. Final determination of fitness for flying duty in questionable cases will be made by Cdr, USAAMC.

Section XX. TUMORS AND MALIGNANT DISEASES

4-28. Malignant Diseases and Tumors

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are—

a. Classes 1 and 1A. Same as paragraph 2-41.

b. Classes 2 and 3. Individuals having a malignant disease or tumor will be considered as medically unfit pending review and evaluation by Cdr, USAAMC.

★ Section XXI. SEXUALLY TRANSMITTED DISEASES

4-29. Sexually Transmitted Diseases

The causes for medical unfitness for flying duty, Classes 1, 1A, 2, and 3 are:

a. Classes 1, 1A, and 2. A history of syphilis unless—

(1) Careful examination shows *no lesions of cardiovascular, neurologic, visceral, mucocutaneous, or osseous syphilis.*

(2) Documentary proof is available that *all provisions of treatment* as contained in direc-

tives current at the time of examination, or equivalent treatment have been fulfilled.

(3) Examination of the spinal fluid (if indicated by current medical protocol) reveals a negative serologic test for syphilis, and a cell count and protein content are within normal limits.

(4) The individual concerned has been clinically cured with no evidence of recurrence for a period of 6 months subsequent to treatment.

b. Class 3.

★Section XXII. ADAPTABILITY RATING FOR MILITARY AERONAUTICS (ARMA) AND READING ALOUD TEST (RAT)

4-30. Adaptability Rating for Military Aeronautics (ARMA)

a. The ARMA is required for all initial flying duty examinations, Classes 1, 1A, 2, 2A, and 3 and, when indicated, for periodic examinations. The cause of medical unfitness for flying duty, all Classes, is an unsatisfactory ARMA due to failure to meet minimum standards of aptitude or psychological factors, or otherwise considered not to be adaptable for military aeronautics.

b. An unsatisfactory ARMA is mandatory if any of the following conditions are present:

(1) Concealment of significant and/or disqualifying medical conditions on the history form or during interviews.

(2) Presence of any psychiatric condition which in itself is disqualifying under chapter 2 or chapter 4.

(3) An attitude toward military flying that is clearly less than optimal; e.g., the person appears to be motivated overwhelmingly by the prestige, pay or other secondary gain rather than the flying itself.

(4) Clearly noticeable personality traits such as immaturity, self-isolation, difficulty with authority, poor interpersonal relationships, impaired impulse control, or other traits which are likely to interfere with group functioning as a team member in a military setting, even though there are insufficient criteria for a personality disorder diagnosis.

(5) Review of the history or medical records reveals multiple or recurring physical complaints that strongly suggest either a somatization disorder or a propensity for physi-

(1) A history or evidence of *primary, secondary, or latent* (spinal fluid negative) *syphilis* until completion of prescribed treatment. Following completion of treatment, individuals may be considered for return to flying status only if the treatment has resulted in clinical cure without sequelae.

(2) A history or evidence of *neurosyphilis* or *tertiary syphilis*.

cal symptoms during times of psychological stress.

(6) A history of arrests, illicit drug use or social "acting out" which indicates immaturity, impulsiveness or antisocial traits. Experimental use of drugs during adolescence, minor traffic violations or clearly provoked isolated impulsive episodes may be accepted but should receive thorough psychiatric and psychological evaluation. (See also para 4-24n.)

(7) Significant *prolonged* or *currently unresolved interpersonal or family problems* (e.g., marital dysfunction; significant family opposition or conflict concerning the servicemember's aviation career), as revealed through record review, interview or other sources which would be a potential hazard to flight safety or would interfere with flight training or flying duty.

c. An unsatisfactory ARMA may be given for lower levels (symptoms and signs) than those mentioned in *b* above if, in the opinion of the flight surgeon, *the mental or physical factors might be exacerbated under the stresses of military aviation or the person might not be able to carry out his or her duties* in a mature and responsible fashion. Additionally, *a person may be disqualified for any of a combination of factors listed in b above and/or due to personal habits or appearance indicative of attitudes of carelessness, poor motivation or other characteristics which are unsafe or undesirable in the aviation environment.*

4-31. Reading Aloud Test (RAT)

The cause of medical unfitness for flying duty, Classes 1, 1A, 2, 2A, and 3 is failure to clearly

enunciate in the English language, as determined by administration of the RAT (app X), in a manner compatible with safe and effective aviation operations. In questionable cases, the avia-

tion unit commander, air traffic control supervisor or other appropriate aviation official will provide a written recommendation to the flight surgeon.

CHAPTER 5

**MEDICAL FITNESS STANDARDS FOR ADMISSION TO US MILITARY
ACADEMY, UNIFORMED SERVICES UNIVERSITY OF HEALTH SCIENCES,
AND ARMY ROTC SCHOLARSHIP**

**(Short Title: USMA, HEALTH SCIENCES UNIVERSITY, AND ROTC
SCHOLARSHIP MEDICAL FITNESS STANDARDS)**

(Rescinded)

Individuals formerly covered under this chapter must meet the standards of chapter 2 for enlistment, appointment, and induction.

CHAPTER 6
MEDICAL FITNESS STANDARDS FOR MOBILIZATION
 (Short Title: MOBILIZATION MEDICAL FITNESS STANDARDS)

Section I. GENERAL

6-1. Scope

This chapter sets forth medical conditions and physical defects which are causes for rejection for entry into the service during mobilization. There are numerous medical conditions and physical defects not specifically mentioned in this chapter which in themselves are not considered unfitting. They may be unfitting, however, if in the opinion of the examining physician the

residuals, complications, or underlying causes of the conditions are of such a nature that they would obviously preclude the individual's satisfactory performance of military duty.

6-2. Applicability

These standards will be implemented only upon specific instruction from the Service Secretaries, and will apply to personnel categories as directed.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

6-3. Abdominal and Gastrointestinal Defects and Diseases

★The causes of medical unfitness for military service are—

a. Achalasia (Cardiospasm): Dysphagia not controlled by dilatation, with continuous discomfort, or inability to maintain weight.

b. Amebic abscess residuals: Persistent abnormal liver function tests after appropriate treatment.

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

d. Cirrhosis of the liver: Recurrent jaundice, ascites, or demonstrable esophageal varices or history of bleeding therefrom; failure to maintain weight and normal vigor.

e. Gastritis: Documented history of severe, chronic hypertrophic gastritis with repeated symptomatology and hospitalization.

f. Hepatitis: Within the preceding 6 months, or persistence of symptoms after a reasonable period of time when objective evidence of impairment of liver function exists.

g. Hernia:

(1) Hiatus hernia: Symptoms not relieved by simple dietary or medical means, or recurrent bleeding in spite of prescribed treatment.

(2) If operative repair is contraindicated for

medical reasons or when not amenable to surgical repair.

h. Ileitis, regional: Confirmed diagnosis thereof.

i. Pancreatitis, chronic: Documented history of frequent abdominal pain of a severe nature; steatorrhea or disturbance of glucose metabolism requiring insulin.

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

j.1. Polyposis of the colon: verified by examination or by documented history.

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

l. Ulcer, peptic, duodenal and gastric: Supported by laboratory and X-ray evidence and documented history of frequent recurrence of symptoms (pain, vomiting, or bleeding).

m. Ulcerative colitis: When supported by documented history of any of the following symptoms: Weight loss, significant abdominal pain, anemia, more than four bowel movements a day.

n. Rectum, stricture of, when supported by documented history of severe symptoms of ob-

struction characterized by intractable constipation, pain on defecation, difficult bowel movements requiring the regular use of laxatives or enemas.

6-4. Gastrointestinal and Abdominal Surgery

The causes of medical unfitness for military service are—

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

b. *Colostomy*. When present.

c. *Enterostomy*. When present.

d. *Gastrectomy*, total per se. Gastrectomy, subtotal with or without vagotomy; gastrojejunostomy, with or without vagotomy;

when residual conditions are such that an individual requires a special diet, develops "dumping syndrome," has frequent episodes of epigastric distress or diarrhea, or shows marked weight loss.

e. *Gastrostomy*. When present.

f. *Ileostomy*. When present.

g. *Pancreatectomy*.

h. *Pancreaticoduodenostomy and Pancreaticogastronomy*: More than mild symptoms of digestive disturbance or requiring insulin.

i. *Pancreaticojejunostomy*: If for cancer in the pancreas or, if more than mild symptoms of digestive disturbance or requiring insulin.

j. *Proctectomy*.

k. *Proctopexy, proctoplasty, proctorrhaphy, and proctotomy*: If fecal incontinence remains.

Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

6-5. Blood and Blood-Forming Tissue Diseases

Any of the following makes the individuals medically unfit for military service when the condition is such as to preclude satisfactory performance of military duty, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged intensive medical supervision.

a. *Anemia*.

b. *Hemolytic crisis*, chronic and symptomatic.

c. *Leukopenia*, chronic and not responsive to therapy.

d. *Polycythemia*.

e. *Purpura and other bleeding diseases*.

f. *Thromboembolic disease*.

g. *Splenomegaly*, chronic and not responsive to therapy.

Section IV. DENTAL

6-6. Dental Diseases and Abnormalities

★The causes of medical unfitness for military service are—

a. *Diseases of the jaws or associated tissues* which will incapacitate the individual or prevent the satisfactory performance of military duty.

b. *Malocclusion*, severe, which interferes with the mastication of a normal diet.

c. *Oral tissues*, extensive loss of, in an amount that would prevent replacement of missing teeth with a satisfactory prosthetic appliance.

d. *Orthodontic appliances*. See special administrative criteria in paragraph 7-16.

e. *Relationship between the mandible and maxilla* of such a nature as to preclude future satisfactory prosthodontic replacement:

Section V. EARS AND HEARING

6-7. Ears

The causes of medical unfitness for military service are—

a. *Infections of the external auditory canal*: Chronic and severe, resulting in thickening and excoriation of the canal or chronic secondary in-

fection requiring frequent and prolonged medical treatment or hospitalization.

b. *Malfunction of the acoustic nerve*: Over 30 decibels hearing level (by audiometer) in the better ear, severe tinnitus which is not corrected satisfactorily by a hearing aid or other

measures, or complicated by vertigo or otitis media.

c. Mastoiditis, chronic, following mastoidectomy. Constant drainage from the mastoid cavity which is resistant to treatment, requiring frequent dispensary care or hospitalization, and a hearing level in the better ear of 30 decibels or more.

d. Meniere's syndrome. Recurring attacks of sufficient frequency and severity as to require hospitalization, and documented by the presence

of objective findings of a vestibular disturbance, not adequately controlled by treatment.

e. Otitis media. Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent hospitalization.

6-8. Hearing

Corrected hearing, within the speech reception score, of 30 decibels or more in the better ear, is unfitting for service.

Section VI. ENDOCRINE AND METABOLIC DISORDERS

6-9. Endocrine and Metabolic Disorders

The causes of medical unfitness for military service are—

a. Acromegaly. Severe with considerable incapacity after treatment.

b. Adrenal hyperfunction. Which has not responded to therapy satisfactorily or where replacement therapy presents serious problems in management.

c. Diabetes insipidus. Unless mild and showing good response to treatment.

d. Diabetes mellitus. Unless mild and controllable by diet.

e. Goiter. With symptoms of obstruction to breathing with increased activity, unless correctable.

f. Gout. Advanced cases with frequent acute exacerbations and/or bone, joint, or kidney damage of such severity as to interfere with satisfactory performance of duty.

g. Hyperinsulinism. When caused by a malign

ant tumor or when the condition is not readily controlled.

h. Hyperparathyroidism per se, does not render an individual medically unfit. However, in the case of residuals or complications of the surgical correction of this condition such as renal disease, or bony deformities which would usually preclude the satisfactory performance of military duty, such individuals are medically unfit for military service.

i. Hyperthyroidism. Severe symptoms of hyperthyroidism which has not responded to treatment, with or without evidence of goiter.

j. Hypofunction, adrenal cortex.

k. Hypoparathyroidism. When not easily controlled by maintenance therapy.

l. Hypothyroidism. When not adequately controlled by medication.

m. Osteomalacia. Residuals after therapy of such nature or degree which would preclude the satisfactory performance of duty.

n. Pituitary basophilism. Confirmed.

Section VII. EXTREMITIES

6-10. Upper Extremities

(See also para 6-12.)

The causes of medical unfitness for military service are—

a. Amputation of arm, or forearm if suitable prosthesis is not available, or double amputee regardless of available prosthesis.

b. Loss of fingers rendering the individual unable to perform useful military service.

c. Joint ranges of motion which do not equal or exceed the measurements listed in (1) to (4)

below (TM 8-640). Range of motion limitations temporarily not meeting these standards, because of disease or injury or remedial condition will be temporarily disqualifying.

(1) *Shoulder.*

(a) Forward elevation to 90°.

(b) Abduction to 90°.

(2) *Elbow.*

(a) Flexion to 100°.

(b) Extension to 60°.

(3) *Wrist.* A total range of 15° (extension plus flexion).

(4) *Hand*. Pronation to the first quarter of the normal arc.

6-11. Lower Extremities

★The causes of medical unfitness for military service are—

a. Amputation of leg, thigh, or foot if suitable prosthesis is not fitted or if the use of a cane or crutches is required, or double amputee regardless of suitable prosthesis.

b. Loss of toes rendering the individual unable to perform useful military service.

c. Feet.

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

(2) *Pes planus*: Symptomatic, more than moderate, with pronation on weight bearing which would prevent the wearing of a military shoe, or when associated with vascular changes.

(2) *Talipes cavus* when moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, and which would prevent the wearing of a military shoe.

d. Internal derangement of the knee. Dislocated semilunar cartilage so disabling as to prevent gainful civilian endeavor.

e. Joint ranges of motion which do not equal or exceed the measurements in (1) through (3) below (TM 8-640). Range of motion limitations temporarily not meeting these standards because of disease or remedial conditions will be temporarily disqualifying.

(1) *Hip*.

(a) Flexion to 90°.

(b) Extension to 10° (beyond 0°).

(2) *Knee*.

(a) Extension to 10°.

(b) Flexion to 90°.

(3) *Ankle*.

(a) Dorsiflexion to 10°.

(b) Plantar Flexion to 10°.

f. Shortening of an extremity which exceeds 2 inches.

6-12. Miscellaneous

(See also para 6-10 and 6-11.)

The causes of medical unfitness for military service are—

a. Arthritis.

(1) *Arthritis due to infection* (not including arthritis due to gonococcal infection or tuberculous arthritis for which see paras 6-34 and 6-39). Associated with persistent pain and marked loss of function, with objective X-ray evidence, and documented history of recurrent incapacity for prolonged periods.

(2) *Arthritis due to trauma*. When there is functional impairment to the involved joints so as to preclude the satisfactory performance of duty.

(3) *Osteoarthritis*. Frequent recurrence of symptoms associated with impairment of function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods, history of frequent recurrences and supported by objective findings.

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

c. Fractures.

(1) *Malunion of fractures*. Where there is more than moderate malunion with marked deformity or more than moderate loss of function.

(2) *Nonunion of fracture*. When nonunion of a fracture interferes with function to the extent of precluding satisfactory performance of duty.

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

(4) *Callus, excessive, following fracture*.

When it interferes with function to the extent of precluding satisfactory performance of military duty.

d. Joints.

(1) *Arthroplasty*. Severe pain, limitation of motion, and the loss of function.

(2) Bony or fibrous ankylosis of weight bearing joints if either fusion is such as to require the use of a cane or crutches or if there is evidence of active or progressive disease.

(3) Contracture of joint: More than moderate, and if loss of function is severe.

(4) Loose foreign bodies within a joint: Complicated by arthritis, not remediable and seriously interfering with function.

e. Muscles.

(1) Paralysis secondary to poliomyelitis if the use of a cane or crutches is required.

(2) Progressive muscular dystrophy: Confirmed.

f. Myotonia congenita. Confirmed.

g. Osteitis deformans (Paget's disease). Involvement in single or multiple bones with resultant de-

formities or symptoms severely interfering with function.

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

i. Osteomyelitis. When recurrent, not responsive to treatment, and involves the bone to a degree which severely interferes with stability and function.

j. Tendon transplantation. Fair or poor restoration of function with weakness which seriously interferes with the function of the affected part.

Section VIII. EYES AND VISION

6-13. Eyes

The causes of medical unfitness for military service are—

a. Active eye disease or any progressive organic eye disease regardless of the stage of activity, resistant to treatment which affects the distant visual acuity or visual fields of an eye to any degree when—

(1) The distant visual acuity cannot be corrected to 20/70 in the better eye.

(2) The diameter of the visual field in the unaffected eye is less than 20 degrees.

b. Aphakia, bilateral.

c. Atrophy of optic nerve due to disease.

d. Chronic congestive (closed angle) glaucoma or chronic noncongestive (open angle) glaucoma if well established, with demonstrable changes in the optic discs or visual fields.

e. Degenerations. When visual loss exceeds the limits shown below or when vision is correctable only by the use of contact lenses, or other special corrective devices (telescopic lenses, etc.).

f. Diseases and infections of the eye. When chronic, more than mildly symptomatic, progressive, and resistant to treatment after a reasonable period.

g. Residuals or complications of injury to the eye which are progressive or which bring vision below the criteria in paragraph 6-14.

h. Retina, detachment of.

(1) *Unilateral.*

(a) When vision in the better eye cannot be corrected to at least 20/70;

(b) When the visual field in the better eye is

constricted to less than 20° in diameter;

(c) When uncorrectable diplopia exists; or

(d) When the detachment is the result of documented organic progressive disease or new growth, regardless of the condition of the better eye.

(2) *Bilateral.* Regardless of etiology or results of corrective surgery.

6-14. Vision

The causes of medical unfitness for military service are—

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

b. Binocular diplopia. Not correctable by surgery, and which is severe, constant, and in zone less than 20° from the primary position.

c. Hemianopsia. Of any type, if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not considered to render an individual unfit.

d. Loss of an eye. An individual with the loss of an eye if suitable prosthesis cannot be tolerated.

e. Night blindness. Of such a degree that the individual requires assistance in any travel at night.

f. Visual acuity which cannot be corrected to at least 20/70 in the better eye with spectacle lenses.

g. Visual field. Constricted to less than 20° in diameter.

Section IX. GENITOURINARY SYSTEM

6-15. Genitourinary System

(See also para 1-16.)

The causes of medical unfitness for military service are—

a. Dysmenorrhea. Symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than one day from civilian occupation.

b. Endometriosis. Symptomatic and incapacitating to a degree which necessitates recurrent absences of more than a day from civilian occupation.

c. Enuresis determined to be a symptom of an organic defect not amenable to treatment.

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

e. Incontinence of urine. Due to disease or defect not amenable to treatment and of such severity as to necessitate repeated absence from civilian occupation.

f. Kidney.

(1) Calculus in kidney: Bilateral, symptomatic and not responsive to treatment.

(2) Bilateral congenital anomaly of the kidney resulting in frequent or recurrent infections, or when there is evidence of obstructive uropathy not responding to medical and/or surgical treatment.

(3) Cystic kidney (polycystic kidney):

(*a*) Symptomatic. Impaired renal function, or if the focus of frequent infections.

(*b*) Asymptomatic, history of, confirmed.

(4) Hydronephrosis: More than mild, bilateral, and causing continuous or frequent symptoms.

(5) Hypoplasia of the kidney: Symptomatic, and associated with elevated blood pressure or frequent infections and not controlled by surgery.

(6) Perirenal abscess residual(s) of a degree which interfere(s) with performance of duty.

(7) Pyelonephritis: Chronic, confirmed.

(8) Pyonephrosis: More than minimal and not responding to treatment following surgical drainage.

(9) Nephrosis.

(10) Chronic glomerulonephritis.

(11) Chronic nephritis.

g. Menopausal syndrome, either physiologic or artificial. More than mild mental and constitutional symptoms.

h. Menstrual cycle irregularities including amenorrhea, menorrhagia, leukorrhea, metrorrhagia, etc., per se, do not render the individual medically unfit.

i. Pregnancy.

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

k. Urethritis, chronic, not responsive to treatment.

l. Albuminuria if persistent or recurrent including so-called orthostatic or functional albuminuria.

6-16. Genitourinary and Gynecological Surgery

The causes of medical unfitness for military

service are—

a. Cystectomy.

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

c. Nephrectomy. Performed as a result of trauma, simple pyogenic infection, unilateral hydronephrosis, or nonfunctioning kidney when after the treatment period the remaining

kidney is functioning abnormally. Residuals of nephrectomy performed for polycystic disease, renal tuberculosis and malignant neoplasm of the kidney must be individually evaluated by a genitourinary consultant and the medical unfitness must be determined on the basis of expected productivity in the service.

d. Nephrostomy. If permanent drainage persists.

e. Oophorectomy. When there remain more than mild mental or constitutional symptoms.

f. Pyelostomy: If permanent drainage persists.

g. Ureterocolostomy.

h. Ureterocystostomy: When both ureters were noted to be markedly dilated with irreversible changes.

i. Ureteroileostomy cutaneous.

j. Ureteroplasty:

(1) When unilateral operative procedure was unsuccessful and nephrectomy was resorted to (c above).

(2) When the obstructive condition is bilateral and residual obstruction or hydronephroses

must be evaluated on an individual basis by a genitourinary consultant and medical fitness for military service determined on the basis of expected productivity in the service.

k. Ureterosigmoidostomy.

l. Ureterostomy: External or cutaneous.

m. Urethrostomy: Complete amputation of the penis or when a satisfactory urethra has not been restored.

n. Medical fitness for military service following other genitourinary and gynecological surgery will depend upon an individual evaluation of the etiology, complication, and residuals.

Section X. HEAD AND NECK

6-17. Head

(See paras 6-28 and 6-29.)

6-18. Neck

(See also para 6-9.)

The causes of medical unfitness for military service are—

Torticollis (wry neck): Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

Section XI. HEART AND VASCULAR SYSTEM

6-19. Heart

The causes of medical unfitness for military service are—

a. Arteriosclerotic heart disease: Associated with myocardial insufficiency (congestive heart failure), repeated anginal attacks, or objective evidence of past myocardial infarction.

b. Auricular fibrillation and auricular flutter: Associated with organic heart disease, and not adequately controlled by medication.

c. Endocarditis: Bacterial endocarditis resulting in myocardial insufficiency.

d. Heart block: Associated with other signs and symptoms or organic heart disease or syncope (Stokes-Adams).

e. Infarction of the myocardium: Documented, symptomatic, and acute.

f. Myocarditis and degeneration of the myocardium: Myocardial insufficiency at a functional level of Class IIC or worse, American Heart Association (app VII).

g. Paroxysmal tachycardia, ventricular or atrial: Associated with organic heart disease or if not adequately controlled by medication.

h. Pericarditis:

(1) *Chronic constructive pericarditis* unless successful remediable surgery has been performed and the individual is able to perform at least relatively sedentary duties without discomfort of dyspnea.

(2) *Chronic serous pericarditis.*

i. Rheumatic valvulitis: Inability to perform duties at a functional level of Class IIC, American Heart Association (app VII).

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

6-20. Vascular System

The causes of medical unfitness for military service are—

a. Arteriosclerosis obliterans: Intermittent claudication of sufficient severity to produce discomfort and disability during a walk of 200 yards or less on level ground at 112 steps per minute.

b. Coarctation of the aorta and other significant congenital anomalies of the cardiovascular

system unless satisfactorily treated by surgical correction.

c. Aneurysm of aorta.

d. Periarteritis nodosa. Confirmed.

e. Chronic venous insufficiency (post-phlebotic syndrome): When more than mild in degree and symptomatic despite elastic support.

f. Raynaud's phenomena: Manifested by trophic changes of the involved parts characterized by scarring of the skin, or ulceration.

g. Thromboangiitis obliterans: Intermittent claudication of sufficient severity to produce discomfort and disability during a walk of 200 yards or less on level ground at 112 steps per minute, or with other complications.

h. Thrombophlebitis: When supported by a history of repeated attacks requiring treatment of such frequency as would interfere with the satisfactory performance of duty.

i. Varicose veins: When more than mild in degree and symptomatic despite elastic support.

6-21. Miscellaneous

The causes of medical unfitness for military service are—

a. Aneurysms:

(1) Acquired arteriovenous aneurysm when more than minimal vascular symptoms remain

following remediable treatment or if associated with cardiac involvement.

(2) Other aneurysms of the artery will be individually evaluated based upon the vessel involved and the residuals remaining after appropriate treatment.

b. Erythromelalgia: Persistent burning pain in the soles or palms not relieved by treatment.

c. Hypertensive cardiovascular disease and hypertensive vascular disease:

(1) Systolic blood pressure consistently over 150 mm of mercury or a diastolic pressure of over 90 mm of mercury following an adequate period of oral therapy while on an ambulatory status.

(2) Any documented history of hypertension regardless of the pressure values if associated with one or more of the following:

(a) More than minimal changes in the brain.

(b) Heart disease.

(c) Kidney involvement.

(d) Grade 2 (Keith-Wagner-Barker) changes in the fundi.

d. Rheumatic fever, active, with or without heart damage: Recurrent attacks.

e. Residuals of surgery of the heart, pericardium, or vascular system resulting in limitation of physical activity at functional level of Class IIC, American Heart Association (app VII).

★Section XII. HEIGHT, WEIGHT AND BODY BUILD (Rescinded)

Section XIII. LUNGS AND CHEST WALL

★6-25. Tuberculous Lesions

The causes of medical unfitness for military service are the same as paragraph 2-25.

a. (Deleted)

b. *Tuberculous empyema.*

c. *Tuberculous pleurisy.* Except when inactive 2 or more years without impaired pulmonary function or associated active pulmonary disease.

6-26. Nontuberculous Lesions

The causes of medical unfitness for military service are—

a. *Bronchial asthma.* Associated with emphysema of sufficient degree to interfere with performance of duty, or frequent attacks controlled only by continuous systemic corticosteroid therapy or frequent attacks which are not controlled by oral medication.

b. *Atelectasis* or massive collapse of the lung: Moderately symptomatic, with or without paroxysmal cough at frequent intervals throughout the day, mild emphysema, or loss in weight.

c. *Bronchiectasis and bronchiolectasis.* Confirmed.

d. *Bronchitis.* Chronic state with persistent cough, considerable expectoration, more than mild emphysema, or dyspnea at rest or on slight exertion.

e. *Cystic disease of the lung, congenital.* Involving more than one lobe in a lung.

f. *Diaphragm, congenital defects.* Symptomatic.

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

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

i. *Pleurisy, chronic, or pleural adhesions.* More than moderate dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions.

j. *Pneumothorax, spontaneous.* Recurring spontaneous pneumothorax requiring hospitalization or outpatient treatment of such frequency as would interfere with the satisfactory performance of duty.

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

l. *Pulmonary emphysema.* Evidence of more than mild emphysema with dyspnea on moderate exertion.

m. *Pulmonary fibrosis.* Linear fibrosis or fibrocalcific residuals of such degree as to cause more than moderate dyspnea on mild exertion.

n. *Pneumoconiosis.* More than moderate, with moderately severe dyspnea on mild exertion, or more than moderate pulmonary emphysema.

o. *Sarcoidosis.* See paragraph 6-35f.

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

q. *Stenosis, trachea.*

6-27. Surgery of the Lungs and Chest

The causes of medical unfitness for military service are—

Lobectomy. Of more than one lobe or if pulmonary function is seriously impaired.

Section XIV. MOUTH, NOSE, PHARYNX, TRACHEA, ESOPHAGUS, AND LARYNX

6-28. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

The causes of medical unfitness for military Service are—

a. Esophagus.

(1) Achalasia unless controlled by medical therapy.

(2) Esophagitis: severe.

(3) Diverticulum of the esophagus of such a degree as to cause frequent regurgitation, obstruction, and weight loss, which has not responded to treatment.

(4) Stricture of the esophagus of such a degree as to almost restrict diet to liquids, which has required frequent dilatation and hospitalization, and has caused the individual to have difficulty in maintaining weight and nutrition, when the condition has not responded to treatment.

b. Larynx.

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

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

c. Obstructive edema of glottis. If chronic, not amenable to treatment and requiring tracheotomy.

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

e. Sinusitis. Severe, chronic sinusitis which is suppurative, complicated by polyps, and which has not responded to treatment.

Section XV. NEUROLOGICAL DISORDERS

6-29. Neurological Disorders

The causes of medical unfitness for military service are—

a. General. Any neurological condition, regardless of etiology, when after adequate treatment there remain residuals, such as persistent and severe headaches, convulsions not controlled by medication, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech or mental defects, and personality changes of such a degree as to definitely interfere with the satisfactory performance of duty.

b. Convulsive disorders except when infrequent convulsions while under standard drugs which are relatively non-toxic and which do not require frequent clinical and laboratory followings.

c. Narcolepsy. When attacks are not controlled by medication.

d. Peripheral nerve condition.

(1) *Neuralgia.* When symptoms are severe, persistent, and has not responded to treatment.

(2) *Neuritis.* When manifested by more than moderate permanent functional impairment.

(3) *Paralysis* due to peripheral nerve injury: When manifested by more than moderate permanent functional impairment.

e. Miscellaneous.

(1) *Migraine.* Cause unknown, when manifested by frequent incapacitating attacks occurring or lasting for several consecutive days and unrelieved by treatment.

(2) *Multiple sclerosis,* confirmed.

★Section XVI. MENTAL DISORDERS

Diagnostic concepts and terms utilized in this section are in consonance with the Diagnostic and Statistical Manual, Third Edition (DSM-III), American Psychiatric Association, 1980.

6-30. Disorders with Psychotic Features

The causes of medical unfitness for military service are—History of a medical disorder with gross impairment in reality testing. This does not include transient disorders associated with intoxication, severe stress or secondary to a toxic, infectious or other organic process.

6-31. Affective Disorders (Mood Disorders)

The causes for rejection for appointment, enlistment and induction are—Persistence or recurrence of symptoms sufficient to require hospitalization or necessity for work in a protected environment.

6-32. Anxiety, Somatoform, or Dissociative Disorders (Neurotic Disorders)

The causes for rejection for appointment, enlistment and reduction are—

a. History of such disorder(s) and:

(1) *Hospitalization.*

(2) *Prolonged care by a physician* or other professionals.

(3) *Loss of time from normal pursuits* for repeated periods even if of brief duration, or

(4) *Symptoms or behavior of a repeated nature* which impair social, school or work efficiency.

b. History of an episode of such disorders within the preceding 12 months which was suffi-

ciently severe to require professional attention or absence from work or school for more than a brief period (maximum of 7 days).

6-32.1. Personality, Behavior, or Learning Disorders

The causes of medical unfitness for military service are—

a. Personality and behavior disorders, as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior which, while not a cause of administrative rejection, are tangible evidence of impaired characterological capacity to adapt to the military service.

b. Personality and behavior disorders where it is evident by history and objective examination that the degree of immaturity, instability, personality inadequacy or dependency will seriously interfere with adjustment in the military service as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow workers, and other society groups.

c. Other behavior problems such as authenticated evidence of enuresis which is habitual or persistent, not due to an organic condition (para 2-15c) occurring beyond early adolescence (age 12 to 14) or stammering or stuttering of such a degree that the individual is normally unable to express himself clearly or to repeat commands.

d. Specific learning defects secondary to organic or functional mental disorders.

e. Alcohol addiction or drug addiction that has failed rehabilitation.

Section XVII. SKIN AND CELLULAR TISSUES

6-33. Skin and Cellular Tissues

The causes of medical unfitness for military service are—

a. Acne. Severe, when the face is markedly disfigured, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by, or would interfere with, the wearing of military equipment.

b. Atopic dermatitis. More than moderate or requiring periodic hospitalization.

c. Amyloidosis: Confirmed.

d. Cysts and tumors. See paragraphs 6-37 and 6-38.

e. Cyst, pilonidal. To be evaluated under provisions of *af* below.

f. Dermatitis herpetiformis. When symptoms have failed to respond to medication.

g. Dermatomyositis. Confirmed.

h. Dermographism. Which would interfere with the satisfactory performance of duty.

i. Eczema. Any type which is chronic and resistant to treatment.

j. Elephantiasis or chronic lymphedema.

k. Epidermolysis bullosa. Confirmed.

l. Erythema multiforme. More than moderate, chronic or recurrent.

m. Exfoliative dermatitis. Of any type, confirmed.

n. Fungus infections, systemic or superficial types. If extensive and not amenable to treatment.

o. Hidradenitis suppurativa and folliculitis decalvans. More than minimal degree.

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

q. Leukemia cutis and mycosis fungoides. In the tumor stage.

r. Lichen planus. Generalized and not responsive to treatment.

s. Lupus erythematosus. Systemic acute or subacute and occasionally the chronic discoid variety with extensive involvement of the skin and mucous membranes or when the condition has not responded to treatment after an appropriate period of time.

t. Neurofibromatosis (Von Recklinghausen's Disease). If repulsive in appearance or when it would interfere with the satisfactory performance of duty.

u. Panniculitis, nodular, nonsuppurative, febrile, relapsing. Confirmed.

v. Parapsoriasis. Extensive and when it would interfere with the satisfactory performance of duty.

w. Pemphigus vulgaris, pemphigus foliaceus, pemphigus vegetans and pemphigus erythematosus. Confirmed.

x. Psoriasis. Extensive and not controllable by treatment and when it would interfere with the satisfactory performance of military duty.

y. Radiodermatitis. If the site of malignant degeneration, or if symptomatic to a degree not amenable to treatment.

z. Scars and keloids. So extensive to adherent that they would seriously interfere with function or with the satisfactory performance of duty or preclude the wearing of necessary military equipment.

aa. Scleroderma. Generalized or of the linear type which seriously interferes with the function of an extremity.

ab. Tuberculosis of the skin. See paragraph 6-35.

ac. Ulcers of the skin. Has not responded to treatment or which would interfere with the satisfactory performance of duty.

ad. Urticaria. Chronic, severe, and not amenable to treatment.

ae. Xanthoma. Regardless of type, only when it would preclude the satisfactory performance of duty.

af. Other skin disorders. If chronic, or of a nature which requires frequent medical care or would interfere with the satisfactory performance of military duty.

Section XVIII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

6-34. Spine, Scapulae, Ribs, and Sacroiliac Joints

(See also para 6-12.)

The causes of medical unfitness for military service are—

a. Congenital anomalies:

(1) *Dislocation, congenital, of hip.*

(2) *Spina bifida:* Associated with pain to the lower extremities, muscular spasm, and limitation of motion which has not been amenable to treatment.

(3) *Spondylolysis or spondylolisthesis* with more than mild symptoms on normal activity.

(4) *Others.* Associated with muscular spasm, pain to the lower extremities, postural deformities, and limitation of motion which have not been amenable to treatment.

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

c. Disarticulation of hip joint.

d. Herniation of nucleus pulposus. More than mild symptoms with sufficient objective findings.

e. Kyphosis. More than moderate, interfering

with function, or causing unmilitary appearance.
f. Scoliosis. Severe deformity with over 2 inches

deviation of tips of spinous processes from the midline.

Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

6-35. Systemic Diseases

The causes of medical unfitness for military service are—

- a. Blastomycosis.*
- b. Brucellosis.* Documented history of chronicity with substantiated recurring febrile episodes, more than mild fatigability, lassitude, depression, or general malaise.
- c. Leprosy of any type.*
- d. Myasthenia gravis.* Confirmed.
- e. Porphyria cutanea tarda.* Confirmed.
- f. Sarcoidosis.* Not responding to therapy or complicated by residual pulmonary fibrosis.
- g. Tuberculosis.*

(1) Active tuberculosis in any form or location or substantiated history of active tuberculosis within the previous 2 years.

(2) Substantiated history of one or more reactivations or relapses of tuberculosis in any form or location or other definite evidence of poor host resistance to the tubercle bacillus.

(3) Residual physical or mental defects from past tuberculosis that would preclude the satisfactory performance of duty.

(4) Tuberculosis of the male genitalia: Involvement of prostate or seminal vesicles and other instances not corrected by surgical excision or when residuals are more than minimal or are symptomatic.

(5) Tuberculosis of the larynx, female genitalia, and kidney.

(6) Tuberculosis of the lymph nodes, skin, bone, joints, intestines, eyes, and peritoneum or mesenteric glands will be evaluated on an individual basis considering the associated involvement, residuals and complications.

6-36. General and Miscellaneous Conditions and Defects

The causes of medical unfitness for military service are—

- a. Allergic manifestations:*
 - (1) Allergic rhinitis (hay fever) (para 6-28d).
 - (2) Asthma (para 6-26a).
 - ★(3) Allergic dermatoses (para 6-33).
 - (4) Visceral, abdominal, and cerebral allergy, if

severe or not responsive to treatment.

b. Any acute pathological condition, including acute communicable diseases, until recovery has occurred without sequelae.

c. Any deformity which is markedly unsightly or which impairs general functional ability to such an extent as would prevent satisfactory performance of military duty.

d. Chronic metallic poisoning especially beryllium, manganese, and mercury. Undesirable residuals from lead, arsenic, or silver poisoning make the examinee medically unacceptable.

e. Cold injury, residuals of (example: frostbite, chilblain, immersion foot, or trench foot), such as a combination of deep seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

f. Positive tests for syphilis with negative TPI test unless there is a documented history of adequately treated lues or any of the several conditions which are known to give a false positive S.T.S. (vaccinia, infectious hepatitis, immunizations, atypical pneumonia, etc.) or unless there has been a reversal to a negative S.T.S. during an appropriate followup period (3 to 6 months).

g. Filariasis; trypanosomiasis; amebiasis; schistosomiasis; uncinariasis (hookworm) associated with anemia, malnutrition, etc., if more than mild, and other similar worm or animal parasitic infestations, including the carrier states thereof.

h. Heat pyrexia (heatstroke, sunstroke, etc.): Documented evidence of predisposition (includes disorders of sweat mechanism and previous serious episode), recurrent episodes requiring medical attention, or residual injury resulting therefrom (especially cardiac, cerebral, hepatic, and renal).

i. Industrial solvent and other chemical intoxication, chronic including carbon bisulfide, trichloroethylene, carbon tetrachloride, and methyl cellosolve.

j. Mycotic infection of internal organs.

k. Myositis or fibrositis; severe, chronic.

l. Residuals of tropical fevers and various parasitic or protozoal infestations which in the opinion of the medical examiner would preclude the satisfactory performance of military duty.

Section XX. TUMORS AND MALIGNANT DISEASES

6-37. Benign Tumors.

The causes of medical unfitness for military service are—

a. Any tumor of the—

- (1) Auditory canal, if obstructive.
- (2) Eye or orbit. See also paragraph 6-13.
- (3) Kidney, bladder, testicle, or penis.
- (4) Central nervous system and its membranous coverings unless 5 years after surgery and no otherwise disqualifying residuals of surgery or original lesion.

b. Benign tumors of the abdominal wall if sufficiently large to interfere with military duty.

c. Benign tumors of the thyroid or other structures of the neck, including enlarged lymph nodes, if the enlargement is of such degree as to interfere with the wearing of a uniform or military equipment.

d. Tongue, benign tumor of, if it interferes with function.

e. Breast, thoracic contents, or chest wall, tumors of, other than fibromata lipomata, and inclu-

sion or sebaceous cysts which are of such size as to interfere with wearing of a uniform or military equipment.

f. For tumors of the internal or external female genitalia, see paragraph 6-16.

g. Ganglioneuroma.

h. Meningeal fibroblastoma, when the brain is involved.

6-38. Malignant Neoplasms

The causes of medical unfitness for military service are—

Malignant growths when inoperable, metastasized beyond regional nodes, have recurred subsequent to treatment, or the residuals of the remedial treatment are in themselves incapacitating.

6-39. Neoplastic Condition of Lymphoid and Blood-Forming Tissues

Noeplastic conditions of the lymphoid and blood-forming tissues are generally considered as rendering an individual medically unfit for military duty.

★ Section XXI. SEXUALLY TRANSMITTED DISEASES

6-40. Sexually Transmitted Diseases

The causes of medical unfitness for military service are—

- a. Aneurysm of the aorta due to syphilis.
- b. Atrophy of the optic nerve due to syphilis.

c. Symptomatic neurosyphilis in any form.

d. Complications or residuals of venereal disease of such chronicity or degree that the individual would not be expected to perform useful duty.

CHAPTER 7
MEDICAL FITNESS STANDARDS FOR MISCELLANEOUS PURPOSES
(Short Title: MISCELLANEOUS MEDICAL FITNESS STANDARDS)

Section I. GENERAL

7-1. Scope.

This chapter sets forth medical conditions and physical defects which are causes for rejection for—

- a. Airborne training and duty, Ranger training and duty, and Special Forces training and duty.
- b. Army service schools.
- c. Diving training and duty.
- d. Enlisted military occupational specialties.

- e. Geographical area assignments.
- f. Service academies other than the US Military Academy.

7-2. Applicability

These standards apply to all applicants or individuals under consideration for selection or retention in these programs, assignments, or duties.

**Section II. MEDICAL FITNESS STANDARDS FOR AIRBORNE TRAINING AND DUTY,
 FREE FALL PARACHUTE TRAINING AND DUTY, RANGER TRAINING AND DUTY,
 AND SPECIAL FORCES TRAINING AND DUTY**

7-3. Medical Fitness Standards for Initial Selection for Airborne Training, Ranger Training, and Special Forces Training

The causes of medical unfitness for initial selection for Airborne training, Ranger training, and Special Forces training are all the causes listed in chapter 2, plus all the causes listed in this section. Entrance into the Special Forces Qualification Course requires disposition of medical reports as described in chapter 10, paragraph 10-29c.

- a. *Abdomen and gastrointestinal system.*
 - (1) Paragraph 2-3.
 - (2) Hernia of any variety.
 - (3) Operation for relief of intestinal adhesions at any time.
 - (4) Laparotomy within a 6-month period.
 - (5) Chronic or recurrent gastrointestinal disorder.
- b. *Blood and blood-forming tissue diseases.*
 - (1) Paragraph 2-4.
 - (2) Sickle cell disease.
 - ★(3) **Rescinded.**
- c. *Dental.* Paragraph 2-5.
- d. *Ears and hearing.*
 - (1) Paragraphs 2-6 and 2-7.
 - (2) Radical mastoidectomy.
 - (3) Any infectious process of the ear until completely healed.

- (4) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of the eustacian tube.

- (5) Recurrent or persistent tinnitus.

- (6) History of attacks of vertigo, with or without nausea, emesis, deafness, or tinnitus.

- e. *Endocrine and metabolic diseases.* Paragraph 2-8.

- f. *Extremities.*

- (1) Paragraphs 2-9, 2-10, and 2-11.

- (2) Less than full strength and range of motion of all joints.

- (3) Loss of any digit from either hand.

- (4) Deformity or pain from an old fracture.

- (5) Instability of any degree of major joints.

- (6) Poor grasping power in either hand.

- (7) Locking of a knee joint at any time.

- (8) Pain in a weight bearing joint.

- g. *Eyes and vision.*

- (1) Paragraphs 2-12 and 2-13 with exceptions noted below.

- (2) For Airborne and Ranger training and duty. Distant visual acuity of any degree that does not correct to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.

- (3) For Special Forces training and duty. Uncorrected distant visual acuity of worse than 20/70 in the better eye or worse than 20/200 in the poorer

eye. Vision which does not correct to 20/20 in at least one eye with spectacle lenses.

(4) *Color vision.* Failure to identify red and/or green as projected by the Ophthalmological Projector or the Stereoscope, Vision Testing. (No requirement for Ranger training.)

h. Genitourinary system. Paragraphs 2-14 and 2-15.

i. Head and neck.

(1) Paragraphs 2-16 and 2-17.

(2) Loss of bony substance of the skull.

(3) Persistent neuralgia; tic douloureux; facial paralysis.

(4) A history of subarachnoid hemorrhage.

j. Heart and vascular system. Paragraphs 2-18, 2-19, and 2-20.

k. Height. No special requirement.

l. Weight. No special requirement.

m. Body build. Paragraph 2-23.

n. Lungs and chest wall.

(1) Paragraphs 2-24, 2-25, and 2-26.

(2) Spontaneous pneumothorax except a single instance of spontaneous pneumothorax if clinical evaluation shows complete recovery with full expansion of the lung, normal pulmonary function, and no additional lung pathology or other contraindication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

o. Mouth, nose, pharynx, larynx, trachea and esophagus. Paragraphs 2-25, 2-26, 2-27 and 2-28.

p. Neurological disorders.

(1) Paragraph 2-29.

(2) Active disease of the nervous system of any type.

(3) Craniocerebral injury (para 4-23a(6)).

q. Mental disorders.

(1) Paragraphs 2-30 through 2-35.

(2) Evidence of excessive anxiety, tenseness, or emotional instability.

(3) Fear of flying as a manifestation of psychiatric illness.

(4) Abnormal emotional responses to situations of stress (both combat and noncombat) when in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of the individual's duties.

r. Skin and cellular tissues. Paragraph 2-36.

s. Spine, scapulae, and sacroiliac joints.

(1) Paragraphs 2-37 and 2-38.

(2) Scoliosis: lateral deviation of tips of vertebral spinous processes more than inch.

(3) Spondylolysis, spondylolisthesis.

(4) Healed fractures or dislocations of the vertebrae.

(5) Lumbosacral or sacroiliac strain, or any history of a disabling episode of back pain, especially when associated with significant objective findings.

t. Systemic disease and miscellaneous conditions and defects.

(1) Paragraphs 2-39 and 2-40.

(2) Chronic motion sickness.

(3) Individuals who are under treatment with any of the mood-ameliorating, tranquilizing, or ataraxic drugs and for a period of 4 weeks after the drug has been discontinued.

(4) Any severe illness, operation, injury, or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual.

u. Tumors and malignant diseases. Paragraph 2-41.

★v. Sexually transmitted diseases. Paragraph 2-42.

7-4. Medical Fitness Standards for Retention for Airborne Duty, Ranger Duty, and Special Forces Duty.

Retention of an individual in Airborne duty, Ranger duty, and Special Forces duty will be based on—

a. His continued demonstrated ability to perform satisfactorily his duty as an Airborne officer or enlisted man, Ranger, or Special Forces member.

b. The effect upon the individual's health and well-being by remaining on Airborne duty, in Ranger duty, or in Special Forces duty.

7-5. Medical Fitness Standards for Initial Selection for Free Fall Parachute Training

The causes of medical unfitness for initial selection for free fall parachute training are the causes listed in chapter 2 plus the causes listed in this section. Disposition of medical reports will be as described in chapter 10, paragraph 10-29c.

a. Abdomen and gastrointestinal system. Paragraph 2-3.

b. Blood and blood-forming disease.

(1) Paragraph 2-4.

(2) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

(3) Sickle cell disease.

★(4) Rescinded.

c. Dental.

(1) Paragraph 2-5.

(2) Any unserviceable teeth until corrected.

d. Ears and hearing.

- (1) Paragraphs 2-6 and 2-7.
- (2) Abnormal labyrinthine function.
- (3) Any infectious process of the ear, including external otitis, until completely healed.
- (4) History of attacks of vertigo with or without nausea; emesis, deafness or tinnitus.
- (5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of eustachian tube.
- (6) Perforation, marked scarring or thickening of the ear drum.

e. Endocrine and metabolic diseases. Paragraph 2-8.*f. Extremities.*

- (1) Paragraphs 2-9, 2-10 and 2-11.
- (2) Any limitation of motion of any joint which might compromise safety.
- (3) Any loss of strength which might compromise safety.
- (4) Instability of any degree or pain in a weight bearing joint.

g. Eyes and vision.

- (1) Paragraphs 2-12 and 2-13.
- (2) Uncorrected distant visual acuity of worse than 20/70 in the better eye or worse than 20/200 in the poorer eye.
- (3) Distant visual acuity of any degree that does not correct to at least 20/30 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, with spectacle lenses.
- (4) Color vision. Failure to identify red and green.

h. Genitourinary system. Paragraphs 2-14 and 2-15.*i. Head and neck.*

- (1) Paragraphs 2-16 and 2-17.
- (2) Loss of bony substance of the skull if retention of personal protective equipment is affected.
- (3) A history of subarachnoid hemorrhage.

j. Heart and vascular system. Paragraphs 2-18, 2-19 and 2-20.*k. Height.* Paragraph 2-21.*l. Weight.* Paragraph 2-22.*m. Body Build.* Paragraph 2-23.*n. Lungs and chest wall.*

- (1) Paragraphs 2-24, 2-25 and 2-26.
- (2) Congenital or acquired defects which restrict pulmonary function, cause air-trapping or affect ventilation/perfusion.
- (3) Spontaneous pneumothorax except a single occurrence at least 3 years before the date of the

examination and clinical evaluation shows complete recovery with normal pulmonary function.

o. Mouth, nose, pharynx, larynx, trachea and esophagus. Paragraphs 2-25, 2-26, 2-27 and 2-28.*p. Neurological disorders.*

- (1) Paragraph 2-31.
- (2) The criteria outlined in paragraph 4-23 for Classes 2 and 3 flying duty apply.

q. Mental disorders.

- (1) Paragraphs 2-30 through 2-35.
- (2) Individuals who are under treatment with any of the mood-ameliorating, tranquilizing or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.
- (3) Evidence of excessive anxiety, tenseness or emotional instability.
- (4) Fear of flying when a manifestation of a psychiatric illness.
- (5) History of psychosis or attempted suicide at any time.
- (6) Phobias which materially influence behavior.

(7) Abnormal emotional response to situations of stress. When in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

r. Skin and cellular tissues. Paragraph 2-36.*s. Spine, scapulae, ribs and sacroiliac joints.*

- (1) Paragraphs 2-37 and 2-38.
- (2) Spondylolysis, spondylolisthesis.
- (3) Healed fracture or dislocation of the vertebrae except mild, asymptomatic compression fracture.
- (4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

t. Systemic diseases and miscellaneous conditions and defects.

- (1) Paragraphs 2-39 and 2-40.
- (2) Blood donations. Personnel will not perform free fall parachute duties for a period of 72 hours following the donation of blood.
- (3) Chronic motion sickness.
- (4) Any severe illness, operation, injury or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

u. Tumors and malignant disease. Paragraph 2-41.*v. Sexually transmitted diseases.* Paragraph 2-42.

7-6. Medical Fitness Standards for Retention for Free Parachute Duty

Retention of an individual in free fall parachute duty will be based on—

a. The servicemember's demonstrated ability to perform satisfactorily free fall parachute duty.

b. The effect upon the individual's health and well-being by remaining on free fall parachute duty.

Section III. MEDICAL FITNESS STANDARDS FOR ARMY SERVICE SCHOOLS**7-7. Medical Fitness Standards for Army Service Schools**

The medical fitness standards for Army service

schools, except as provided elsewhere herein, are covered in DA Pam 351-4.

Section IV. MEDICAL FITNESS STANDARDS FOR DIVING TRAINING AND DUTY**7-8. Medical Fitness Standards for Initial Selection for Marine (SCUBA) Diving Training (Special Forces and Ranger Combat Diving)**

The causes of medical unfitness for initial selection for marine self-contained underwater breathing apparatus (SCUBA) diving training are the causes listed in chapter 2 plus the causes listed in this section. Disposition of medical reports will be as described in chapter 10, paragraph 10-29c.

a. *Abdomen and gastrointestinal system.* Paragraph 2-3.

b. *Blood and blood-forming disease.*

(1) Paragraph 2-4.

(2) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

(3) Sickle cell disease.

★(4) Rescinded.

c. *Dental.*

(1) Paragraph 2-5.

(2) Any infectious process and any conditions which contribute to recurrence until eradicated.

(3) Edentia; any unserviceable teeth until corrected.

(4) Moderate malocclusion extensive restoration or replacement by bridges or dentures which interfere with the use of SCUBA. Residual teeth and fixed appliances must be sufficient to allow the individual to easily retain a SCUBA mouthpiece.

d. *Ears and hearing.*

(1) Paragraphs 2-6 and 2-7.

(2) Persistent or recurrent abnormal labyrinthine function as determined by appropriate tests.

(3) Any infectious process of the ear, including external otitis, until completely healed.

(4) History of attacks of vertigo with or without nausea, emesis, deafness or tinnitus.

(5) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of eustachian tube. See pressure test requirement, paragraph 7-8w.

(6) Perforation, marked scarring or thickening of the eardrum.

e. *Endocrine and metabolic diseases.* Paragraph 2-8.

f. *Extremities.*

(1) Paragraphs 2-9, 2-10 and 2-11.

(2) Any limitation of motion of any joint which might compromise safety.

(3) Any loss of strength which might compromise safety.

(4) Instability of any degree or pain in a weight-bearing joint.

(5) History of osteonecrosis (aseptic necrosis of the bone) of any type.

g. *Eyes and vision.*

(1) Paragraphs 2-12 and 2-13.

(2) Vision which does not correct to 20/20 in at least one eye.

(3) Color vision. Failure to identify red and/or green as projected by the Ophthalmological Projector or the Stereoscope Vision Testing.

h. *Genitourinary system.* Paragraphs 2-14 and 2-15.

i. *Head and neck.*

(1) Paragraphs 2-16 and 2-17.

(2) Loss of bony substance of the skull if retention of personal protective equipment is affected.

(3) History of subarachnoid hemorrhage.

j. *Heart and vascular system.* Paragraphs 2-18, 2-19 and 2-20.

k. *Height.* Paragraph 2-21.

l. *Weight.*

(1) Paragraph 2-22.

(2) The individual must meet the weight stand-

ards prescribed by AR 600-9. The medical examiner may impose body fat measurements not otherwise requested by the commander.

m. Body build.

- (1) Paragraph 2-23.
- (2) Obesity of any degree.

n. Lungs and chest wall.

- (1) Paragraph 2-24.
- (2) Congenital or acquired defects which restrict pulmonary function, cause air-trapping or affect ventilation/perfusion.

(3) Spontaneous pneumothorax except a single occurrence at least 3 years before the date of the examination and clinical evaluation shows complete recovery with normal pulmonary function.

o. Mouth, nose, pharynx, larynx, trachea and esophagus. Paragraphs 2-25, 2-26, 2-27 and 2-28.

p. Neurological disorders.

- (1) Paragraph 2-29.
- (2) The criteria outlined in paragraph 4-23 for Classes 2 and 3 flying duty apply.

q. Disorders with psychotic features, affective disorders (mood disorders), anxiety, somatoform or dissociative disorders (neurotic disorders).

- (1) Paragraphs 2-30 through 2-35.
- (2) Individuals who are under treatment with any of the mood-ameliorating, tranquilizing or ataraxic drugs for hypertension, angina pectoris, nervous tension, instability, insomnia, etc., and for a period of 4 weeks after the drug has been discontinued.
- (3) Evidence of excessive anxiety, tenseness or emotional instability.
- (4) Fear of flying when a manifestation of a psychiatric illness.
- (5) History of psychosis or attempted suicide at any time.
- (6) Phobias which materially influence behavior.

(7) Abnormal emotional response to situations of stress. When in the opinion of the medical examiner such reactions will interfere with the efficient and safe performance of duty.

(9) Fear of depths, inclosed places or of the dark.

r. Skin and cellular tissues. Paragraph 2-36.

s. Spine, scapulae, ribs and sacroiliac joints. (Consultation with an orthopedist and, if available, diving medical officer will be obtained in questionable cases.)

- (1) Paragraphs 2-39 and 2-40.
- (2) Spondylolisthesis; spondylolysis which is

symptomatic or likely to interfere with diving duty.

(3) Healed fracture or dislocation of the vertebrae except mild, asymptomatic compression fracture.

(4) Lumbosacral or sacroiliac strain when associated with significant objective findings.

t. Systemic diseases and miscellaneous conditions and defects.

- (1) Paragraphs 2-39 and 2-40.
- (2) Chronic motion sickness.

(3) Any severe illness, operation, injury or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe performance of duty.

u. Tumors and malignant diseases. Paragraph 2-41.

★v. Sexually transmitted diseases. Paragraph 2-42.

w. If a hyperbaric chamber is available, examinees will be tested for the following disqualifying conditions:

(1) *Failure to equalize pressure.* All candidates shall be subjected in a compression chamber to a pressure of 50 pounds (22.5 kg) per square inch to determine their ability to withstand the effects of pressure, to include ability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver. This test should not be performed in the presence of a respiratory infection that may temporarily impair the ability to equalize or ventilate.

(2) *Oxygen intolerance.* Individual susceptibility to oxygen shall be tested by determining the candidate's ability to breathe oxygen without deleterious effects at a pressure to 27 pounds (12.15 kg)(60 feet)(18 meters) for a period of 30 minutes.

7-9. Medical Fitness Standards for Retention for Marine (SCUBA) Diving Duty (Special Forces and Ranger Combat Diving)

Retention of an individual in marine (SCUBA) diving duty will be based on—

a. The servicemember's demonstrated ability to perform satisfactorily marine (SCUBA) diving duty.

b. The effect upon the individual's health and well-being by remaining on marine (SCUBA) diving duty.

7-10. Medical Fitness Standards for Initial Selection for Other Marine Diving Training (MOS 00B)

★SF 88 (Report of Medical Examination), SF 93 (Report of Medical History), and allied documents will be sent to HQDA (SGPS-CP-B), Falls Church VA 22041-3258, for review and approval. (See also paras 10-16c(2) and app IX for medical examination requirements.)

The causes of medical unfitness for initial selection for diving training are all of the causes listed in chapter 2, plus all of the causes listed in this section.

a. Abdomen and gastrointestinal system.

- (1) Paragraph 2-3.
- (2) Hernia of any variety.
- (3) Operation for relief of intestinal adhesions at any time.
- (4) Chronic or recurrent gastrointestinal disorder which may interfere with or be aggravated by diving duty. Severe colitis, peptic ulcer disease, pancreatitis, and chronic diarrhea are disqualifying unless asymptomatic on an unrestricted diet for 24 months and no radiographic or endoscopic evidence of active disease or severe scarring or deformity.

(5) Laparotomy or celiotomy within the preceding 6 months.

b. Blood and blood-forming tissue diseases.

- (1) Paragraph 2-4.
- ★(2) Sickle cell disease.
- (3) Significant anemia or history of hemolytic disease due to variant hemoglobin state.

c. Dental.

- (1) Paragraph 2-5.
- (2) Any infectious process and any conditions which contribute to recurrence until eradicated.
- (3) Edentia; any unserviceable teeth until corrected.
- (4) Moderate malocclusion, extensive restoration or replacement by bridges or dentures, which interfere with use of SCUBA. Residual teeth and fixed appliances must be sufficient to allow the individual to easily retain a SCUBA mouthpiece.

d. Ears and hearing.

- (1) Paragraphs 2-6 and 2-7.
- (2) Perforation, marked scarring or thickening of the eardrum.
- (3) Inability to equalize pressure on both sides of the eardrums by Valsalva or similar maneuver while under 50 pounds of pressure in a compression chamber. See paragraph 7-8w.

(4) Acute or chronic disease of the auditory canal, tympanic membrane, middle or internal ear.

(5) Hearing sensitivity level in either ear by reliable audiometric testing (regardless of conversa-

tional or whispered voice hearing sensitivity) which exceeds 20 decibels at any of the frequencies 250, 500, 1000, 2000 or which exceeds 45 decibels at frequency 4000.

(6) History of otitis media or otitis externa with any residual effects which might interfere with or be aggravated by diving duty.

e. Endocrine and metabolic diseases. Paragraph 2-8.

f. Extremities.

- (1) Paragraphs 2-9, 2-10 and 2-11.
- (2) History of any chronic or recurrent orthopedic pathology which would interfere with diving duty.
- (3) Loss of any digit or portion thereof of either hand which significantly interferes with normal diving duties.

(4) Fracture or history of disease or operation involving any major joint until reviewed by a diving medical officer.

(5) Any limitation of the strength or range of motion of any of the extremities which would interfere with diving duty.

g. Eyes and vision.

- (1) Paragraph 2-12.
- (2) Distant visual acuity, uncorrected, of less than 20/70 (better eye) and 20/200 (poorer eye); not correctable to 20/20.
- (3) Near visual acuity, uncorrected, of less than 20/50 or not correctable to 20/20.

(4) Color vision:

- (a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set, or
- (b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set.

(c) When administered in lieu of (a) or (b) above, failure to pass the Farnsworth Lantern Test (FALANT) (USN Test).

(d) Waivers may be granted by the reviewing authority if the examinee can correctly identify the red, green and brown colors used in diving operations. Such testing will include sufficient repetitions to insure against examinee passing by chance.

(5) Abnormalities of any kind noted during ophthalmoscopic examination which significantly affect visual function or indicate serious systemic disease.

h. Genitourinary system.

- (1) Paragraphs 2-14 and 2-15.
- (2) Chronic or recurrent genitourinary disease or complaints, including glomerulonephritis and pyelonephritis.

(3) Abnormal findings by urinalysis, including significant proteinuria and hematuria.

(4) Varicocele, unless small and asymptomatic.

i. Head and neck. Paragraphs 2-16, 2-17 and 4-14.

j. Heart and vascular system.

(1) Paragraphs 2-18, 2-19 and 2-20.

(2) Varicose veins which are symptomatic or may become symptomatic as a result of diving duty; deep vein thrombophlebitis; gross venous insufficiency.

(3) Marked or symptomatic hemorrhoids.

(4) Any circulatory defect (shunts, stasis and others) resulting in increased risk of decompression sickness.

(5) Persistent tachycardia or arrhythmia except for sinus type.

k. Height. Less than 66 or more than 76 inches.

l. Weight. Weight related to height which is outside the limits prescribed by AR 600-9.

m. Body build.

(1) Paragraph 2-23.

(2) Obesity. Even though the individual's weight or body composition is within the limits prescribed by AR 600-9, he will be found medically unfit if the examiner considers that his weight and/or associated conditions in relationship to the bony structure, musculature and/or total body fat content would adversely affect diving safety or endanger the individual's well-being if permitted to continue in diving status.

n. Lungs and chest wall.

(1) Paragraph 2-24.

(2) Congenital or acquired defects which restrict pulmonary function, cause air trapping or affect ventilation-perfusion ratio.

(3) Any chronic obstructive or restrictive pulmonary disease at the time of examination.

o. Mouth, nose, pharynx, larynx, trachea and esophagus.

(1) Paragraphs 2-25, 2-26, 2-27 and 2-28.

(2) History of chronic or recurrent sinusitis at any time.

(3) Any nasal or pharyngeal respiratory obstruction.

(4) Chronically diseased tonsils until removed.

(5) Speech impediments of any origin; any condition which interferes with the ability to communicate clearly in the English language.

p. Neurological disorders.

(1) Paragraph 2-29.

(2) The special criteria which are outlined in

paragraph 4-24 for Class 1 flying duty are also applicable to diving duty.

q. Mental disorders.

(1) Paragraphs 2-30 through 2-35.

(2) The special criteria which are outlined in paragraph 4-24 for Class 1 flying duty are also applicable to diving duty.

(3) Fear of depths, inclosed places, or of the dark.

r. Skin and cellular tissues. Any active or chronic disease of the skin.

s. Spine, scapulae, ribs, and sacroiliac joints.

(1) Paragraphs 2-37 and 2-38.

(2) Spondylolysis, spondylolisthesis.

(3) Healed fractures or dislocations of the vertebrae until reviewed by a diving medical officer.

(4) Lumbrosacral or sacroiliac strain, or any history of a disabling episode of back pain, especially when associated with significant objective findings.

t. Systemic diseases and miscellaneous conditions and defects.

(1) Paragraphs 2-39 and 2-40.

(2) Any severe illness, operation, injury, or defect of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe driving.

u. Tumors and malignant diseases. Paragraph 2-41.

★*v. Sexually transmitted diseases.*

(1) Active sexually transmitted disease until adequately treated.

(2) History of clinical or serological evidence of active or latent syphilis, unless adequately treated, or of cardiovascular or central nervous system involvement at any time. Serological test for syphilis required.

w. Oxygen intolerance. See paragraph 7-8w.

7-11. Medical Fitness Standards for Retention for Other Marine Diving Duty (MOS 00B)

The medical fitness standards contained in paragraph 7-10 apply to all personnel performing diving duty except that divers of long experience and a high degrees of efficiency—

a. Must be free from disease of the auditory, cardiovascular, respiratory, genitourinary and gastrointestinal system.

b. Must maintain their ability to equalize air pressure.

c. Uncorrected visual acuity, near and far, of not

less than 20/100 in the better eye, correctable to not less than 20/30.

Section V. MEDICAL FITNESS STANDARDS FOR ENLISTED MILITARY OCCUPATIONAL SPECIALTIES

7-12. Medical Fitness Standards for Enlisted Military Occupational Specialties

a. The medical fitness standards to be utilized in the initial selection of individuals to enter a specific enlisted military occupational specialty (MOS) are contained in AR 611-201. Visual acuity requirements for this purpose will be based upon the individuals' vision corrected by spectacle lenses.

b. Individuals who fail to meet the minimum medical fitness standards established for a particular enlisted MOS, but who perform the duties of the MOS to the satisfaction of the commander concerned are medically fit to be retained in that specialty except when there is medical evidence to the effect that continued performance therein will adversely affect their health and well-being.

Section VI. MEDICAL FITNESS STANDARDS FOR CERTAIN GEOGRAPHICAL AREAS

7-13. Medical Fitness Standards for Certain Geographical Areas

a. All individuals considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States are medically qualified to serve in similar or corresponding areas outside the continental United States.

b. Certain individuals, by reason of certain medical conditions or certain physical defects, may require administrative consideration when assignment to certain geographical areas is contemplated to insure that they are utilized within their medical capabilities without undue hazard to their health and well-being. In many instances, such individuals can serve effectively in a specific assignment when the assignment is made on an individual basis considering all of the administrative and medical factors. Guidance as to assignment limitations indicated for various medical conditions and physical defects is contained in chapter 9 and *c* below.

c. MAAGs, military attachés, military missions and duty in isolated areas (see AR 55-46, AR 600-200, and AR 612-2).

(1) The following medical conditions and defects will preclude assignments or attachment to duty with MAAGs, military attachés, military missions, or any type duty in isolated oversea stations requiring residence in areas where US military medical treatment facilities are limited or nonexistent:

(a) A history of peptic ulcer which has required medical or surgical management within the preceding 3 years.

(b) A history of colitis.

(c) A history of emotional or mental disorders, including character disorders, of such a degree as to have interfered significantly with past adjustment or to be likely to require treatment during this tour.

d. Any medical condition where maintenance medication is of such toxicity as to require frequent clinical and laboratory followup.

e. Inherent, latent, or incipient medical or dental conditions which are likely to be aggravated by climate or general living environment prevailing in the area where the individual is expected to reside, to such a degree as to preclude acceptable performance of duty.

(2) Of special consideration is a thorough evaluation of a history of chronic cardiovascular, respiratory, or nervous system disorders. This is especially important in the case of individuals with these disorders who are scheduled for assignment and/or residence in an area 6,000 feet or more above sea level. While such individuals may be completely asymptomatic at the time of examination, hypoxia due to residence at high altitude may aggravate the condition and result in further progression of the disease. Examples of areas where altitude is an important consideration are La Paz, Bolivia; Quito, Ecuador; Bogota, Colombia; and Addis Ababa, Ethiopia.

(3) Remediable medical, dental, or physical conditions or defects which might reasonably be expected to require care during a normal tour of duty in the assigned area are to be corrected prior to departure for CONUS.

(4) Findings and recommendations of the examining physicians and dentists will be based en-

tirely on the examination and a review of the health record, either outpatient or inpatient medical records. Motivation of the examinee *must* be minimized and recommendations based only on the professional judgment of the examiners.

d. The medical fitness standards set forth in c above are prescribed for the purpose of meeting se-

lection criteria for military personnel under consideration for assignment or attachment to duty with MAAGs, military attachés, military missions or any type duty in isolated overseas stations. These fitness standards also pertain to dependents of personnel being considered.

Section VII. MEDICAL FITNESS STANDARDS FOR ADMISSION TO SERVICE ACADEMIES OTHER THAN US MILITARY ACADEMY

7-14. Medical Fitness Standards for Admission to US Naval Academy

The medical fitness standards for admission to the United States Naval Academy are set forth in chapter 15 of the Manual of the Medical Department. US Navy, as well as NAVPERS 15010 Regulations Governing the Admission of Candidates into the United States Naval Academy as Midshipmen. The Manual of the Medical Department may be obtained from the Naval Medical Command, Code 09B21, Room 3009, 2300 E Street, NW, Washington, DC 20372. The NAVPERS 15010 Regulations are avail-

able at the Naval Publications and Forms Center, 5801 Tabor Avenue, Philadelphia, PA 19120.

7-15. Medical Fitness Standards for Admission to US Air Force Academy

The medical fitness standards for admission to the United States Air Force Academy are set forth in section VI of AFM 160-1, Medical Examination. The special administrative criteria in paragraphs 7-16 through 7-19 are listed for the information and guidance of all concerned. AFM 160-1 may be obtained from HQ US Air Force, PDO 4008A, Bolling Air Force Base, Washington, DC 20372.

Section VIII. SPECIAL ADMINISTRATIVE CRITERIA APPLICABLE TO CERTAIN MEDICAL FITNESS REQUIREMENTS

7-16. Dental—Induction, Enlistment or Appointment (See para 2-5.)

a. Except for physicians, dentists and allied medical specialists, individuals who have orthodontic appliances and who are under active treatment are administratively unacceptable for enlistment or induction into the Active or Reserve Components of the Army, Air Force, Navy and Marine Corps for an initial period not to exceed 12 months from the date that treatment was initiated. Selective service registrants will be reexamined after the 12-month period. After the 12-month period, wherein a longer period of treatment is allegedly required, the registrant will be scheduled by the examining MEPS for consultation by a civilian or military orthodontist, and the report of this consultation will be forwarded through the Chief, Medical Section, Headquarters, United States Army Recruiting Command, Fort Sheridan, IL 60037-5570, to the Commander, United States Army Health Services Command, Fort Sam Houston, TX 78234-6000, for final determination of acceptability. The Commanding General, United States Army Health Services Command

will coordinate, as appropriate with the Surgeon General, US Air Force, or the Surgeon General of the Navy on individuals whose induction into the Air Force, Navy, or Marine Corps is being considered. Physicians, dentists, and allied medical specialists liable for induction will be evaluated in accordance with the standards prescribed by chapter 2 of this regulation.

c. Officers and enlisted personnel of the Active Army, Army National Guard, and the Army Reserve are acceptable for active duty, or active duty for training if the orthodontic appliances were fixed subsequent to the date of original appointment or enlistment.

d. Cadets at the USMA or in the ROTC are also acceptable for appointment and active duty if the orthodontic appliances were affixed prior to or since entrance into these programs.

★e. Individuals undergoing orthodontic care are acceptable for enlistment in the Delayed Entry Program or a Reserve Component of the Army, Air Force, Navy, and Marine Corps only if a civilian or military orthodontist provides documentation that

active orthodontic treatment will have been completed prior to entry on initial active duty for training or active duty. Individuals with retainer orthodontic appliances who are not required to undergo further active treatment are administratively acceptable for appointment, enlistment, induction, initial active duty for training, or active duty status.

7-17. Height—Regular Army Commission

Individuals being considered for appointment in the Regular Army who are over the maximum or under the minimum height standards will automatically be considered on an individual basis for an administrative waiver by Headquarters, Department of the Army, during the processing of their applications.

7-18. Height—USMA, ROTC and Uniformed Services University of the Health Sciences

The following applies to all candidates to the USMA, ROTC and the Uniformed Services University of the Health Sciences:

Candidates for admission to the USMA, ROTC and the Uniformed Services University of the Health Sciences, who are over the maximum height or below the minimum height, will automatically be recommended by the Department of Defense Medical Review Board for consideration for an administrative waiver by Headquarters, Department of the Army, during the processing of their cases, which may be granted provided they have exceptional educational qualifications, have an outstanding military record or have demonstrated outstanding abilities.

7-19. Vision—Officer Assignment to Armor, Artillery, Infantry, Corps and Engineers, Military Intelligence, Military Police Corps, and Signal Corps

★*a.* Individuals being initially appointed or as-

signed as officers in Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps may possess uncorrected distance visual acuity of any degree that corrects with spectacle lenses to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error, and be able to identify without confusion the colors vivid red and vivid green. Refractive error corrected by orthokeratology or keratorefractive surgery is disqualifying.

b. Retention of an officer in any of the branches listed in *a* above will be based on:

(1) The officer's demonstrated ability to perform appropriate duties commensurate with his or her age and grade.

(2) The officer's medical fitness for retention in Army service shall be determined pursuant to chapter 3, including paragraphs 3-15 and 3-16.

(3) If the officer is determined to be medically unfit for retention in Army service, but is continued on active duty or in Reserve Component service not on active duty under appropriate regulations, such continuance may also constitute a basis for retention of the officer in any of the branches listed in *a* above.

7-19.1. Hearing—Officer Assignment to Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps and Signal Corps

a. Individuals being initially appointed or assigned as officers in these branches may not possess hearing levels greater than those levels cited as Profile serial H-1, appendix VIII, this regulation.

b. Retention of an officer in any of the branches listed in (*a*) above will be based on:

(1) The officer's demonstrated ability to perform appropriate duties commensurate with his or her age and grade, and

(2) The officer's medical fitness for retention in Army service under chapter 3, paragraph 3-10.

**Section IX. MEDICAL FITNESS STANDARDS FOR TRAINING AND DUTY AS NUCLEAR
POWERPLANT OPERATORS AND/OR OFFICER-IN-CHARGE (OIC) NUCLEAR POWERPLANT
(Ref. TB MED 267)**

7-20. Medical Fitness Standards for Training and Duty at Nuclear Powerplants

The causes for medical unfitness for initial selection, training, and duty as nuclear powerplant operators and/or officer-in-charge (OIC) nuclear powerplants are all the causes listed in chapter 2, plus the following:

- a. Paragraph 7-13c.
- b. Inability to distinguish and identify without confusion the color of an object, substance, material, or light that is uniformly colored a vivid red or a vivid green.
- c. Familial history of any of the following (refer to TB MED 267):
 - (1) Congenital malformations.
 - (2) Leukemia.
 - (3) Blood clotting disorders.
 - (4) Mental retardation.

- (5) Cancer.
- (6) Cataracts (early).
- d. Abnormal results from the following studies which will be accomplished (see TB MED 267):
 - (1) White cell count (with differential).
 - (2) Hematocrit.
 - (3) Hemoglobin.
 - (4) Red cell morphology.
 - (5) Sickle cell preparation (regardless of race).
 - (6) Platelet count.
 - (7) Fasting blood sugar.
- e. Presence or history of psychiatric illness requiring hospitalization or extensive treatment, or personality disorders, including alcoholism, where either, in the opinion of the examining officer, would make assignment at this specialty inadvisable.

Section X. SPECIAL MEDICAL FITNESS STANDARDS FOR AVIATION TRAINING

7-21. Federal Aviation Administration-Rated Personnel

When so directed in special procurement programs prescribed by the Department of the Army or the National Guard Bureau, personnel possessing current valid FAA private pilot certificates or higher certificates may be medically qualified for initial Army aviation flight training under Army Class 2 medical fitness standards.

7-22. Senior Career Officers

Selected senior career officers of the Army in the grades of lieutenant colonel, promotable, and colonel may be medically qualified for initial flight training under the following medical fitness standards:

- a. Class 2, medical fitness standards for flying as

prescribed in chapter 4, except—

- (1) *Vision*. Uncorrected distant visual acuity of less than 20/100 in each eye or not correctable with spectacle lenses to 20/20 in each eye. Near visual acuity not correctable to 20/20 in each eye with spectacle lenses.
- (2) *Refractive error*.
 - (a) *Astigmatism*. Greater than 1.00 diopter.
 - (b) *Hyperopia*. Greater than 1.75 diopters for individuals under the age of 35 years and greater than 2.00 diopters for individuals age 35 and over, in any meridian.
 - (c) *Myopia*. Greater than 1.25 diopters in any meridian regardless of age.
 - ★(d) *Refractive error corrected by orthokeratology or keratorefractive surgery*.
 - b. Unsatisfactory ARMA.

9 February 1987

C 35, AR 40-501

★CHAPTER 8
MEDICAL FITNESS STANDARDS FOR PHYSICIANS, DENTISTS, AND
ALLIED MEDICAL SPECIALISTS
(Short Title: MEDICAL SPECIALISTS MEDICAL FITNESS STANDARDS)
(Rescinded)

Individuals formerly covered under this chapter must meet the standards of chapter 2 for enlistment, appointment, and induction, and chapter 3 for retention.

CHAPTER 9 PHYSICAL PROFILING

9-1. Scope

This chapter sets forth a system of classifying individuals according to functional abilities.

9-2. Applicability

The physical profile system is applicable to the following categories of personnel:

a. Registrants who undergo an induction or pre-induction medical examination related to Selective Service processing.

b. Applicants for enlistment or appointment in the United States Army (Active and Reserve Components).

c. Applicants for enlistment or appointment in the United States Marine Corps.

d. Applicants for enlistment in the United States Air Force.

e. Applicants for enlistment in the United States Navy when examined at military enlistment processing stations.

f. Members of any component of the United States Army throughout their military service, whether or not on active duty.

9-3. General

a. The physical profile serial system described herein is based primarily upon the function of body systems and their relation to military duties. The functions of the various organs, systems, and integral parts of the body are considered. Since the analysis of the individual's medical, physical, and mental status plays an important role in assignment and welfare, not only must the functional grading be executed with great care, but clear and accurate descriptions of medical, physical, and mental deviations from normal are essential. The limitations must be fully described for the various codes in paragraph 9-5. This information will assist the unit commander and personnel officer in their determination of individual assignment or reclassification action. In developing the system, the functions have been considered under six factors. For ease in accomplishing and applying the profile sys-

tem, these factors have been designated "P-U-L-H-E-S." Four numerical designations are used to reflect different levels of functional capacity. The basic purpose of the physical profile serial is to provide an index to overall functional capacity. Therefore, the functional capacity of a particular organ or system of the body, rather than the defect per se, will be evaluated carefully in determining the numerical designation 1, 2, 3 or 4.

b. Aids such as X-ray films, electrocardiograms, and other specific tests which give objective findings will also be given due consideration. The factor to be considered, the parts affected, and the bodily function involved in each of these factors are as follows:

(1) P—*Physical capacity or stamina*. This factor concerns general physical capacity. It normally includes conditions of the heart; respiratory system; gastrointestinal system; genitourinary system; nervous system; allergic; endocrine, metabolic, and nutritional diseases; diseases of the blood and blood-forming tissues; dental conditions; diseases of the breast; and other organic defects and diseases which do not fall under other specific factors of the system. In arriving at a profile under this factor, it may be appropriate to consider build, strength, endurance, height-weight-body build relationship, agility, energy, and muscular coordination.

(2) U—*Upper extremities*. This factor concerns the hands, arms, shoulder girdle, and spine (cervical, thoracic, and upper lumbar) in regard to strength, range of motion, and general efficiency.

(3) L—*Lower extremities*. This factor concerns the feet, legs, pelvic girdle, lower back musculature, and lower spine (lower lumbar and sacral) in regard to strength, range of motion, and general efficiency.

(4) H—*Hearing and ear*. This factor concerns auditory acuity and diseases and defects of the ear.

(5) E—*Eyes*. This factor concerns visual acuity and diseases and defects of the eye.

(6) S—*Psychiatric*. This factor concerns personality, emotional stability, and psychiatric diseases.

c. Four numerical designations are assigned for

evaluating the individual's functional capacity in each of the six factors.

(1) An individual having a numerical designation of "1" under all factors is considered to possess a high level of medical fitness and, consequently, is medically fit for any military assignment.

(2) A physical profile "2" under any or all factors indicates that an individual possesses some medical condition or physical defect which may impose some limitations on classification and assignment. Individuals with numerical designator "2" under one or more factors, who are determined by a medical board to require an assignment limitation, may be awarded specific assignment limitations.

(3) A profile containing one or more numerical designators "3" signifies that the individual has medical condition(s) or physical defect(s) which require certain restrictions in assignment within which the individual is physically capable of performing military duty. They should receive assignments commensurate with their functional capability.

(4) A profile serial containing one or more numerical designators "4" indicates that the individual has one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited. The numerical designator "4" does *not* necessarily mean that the member is unfit because of physical disability as defined in AR 635-40. When a numerical designator "4" is used, there are significant assignment limitations which must be fully described if such an individual is returned to duty. Code "V," "W" or "Y" is required (para 9-5).

★*d.* Anatomical defects or pathological conditions will not of themselves form the sole basis for recommending assignment or duty limitations. While these conditions must be given consideration when accomplishing the profile, the prognosis and the possibility of further aggravation must also be considered. IN THIS RESPECT, PROFILING OFFICERS MUST CONSIDER THE EFFECT OF THEIR RECOMMENDATIONS UPON THE SOLDIER'S ABILITY TO PERFORM DUTY. PROFILES INCLUDING ASSIGNMENT LIMITATIONS, TEMPORARY OR PERMANENT, WHICH ARE RECORDED ON DA FORM 3349, PHYSICAL PROFILE PRESCRIBED BY THIS CHAPTER OR ON DD FORM 689, INDIVIDUAL SICK SLIP (FOR TEMPORARY PROFILES NOT TO EXCEED 30 DAYS AS PRESCRIBED BY AR 600-6), MUST BE REALISTIC. ALL PROFILES AND ASSIGNMENT

LIMITATIONS MUST BE LEGIBLE, SPECIFIC AND WRITTEN IN LAY TERMS. SINCE PERFORMANCE OF ARMY DUTY AND ARMY UNIT EFFECTIVENESS ARE MAJOR CONSIDERATIONS, A CLOSE PERSONAL RELATIONSHIP MUST EXIST BETWEEN PHYSICIANS AND UNIT COMMANDERS OR PERSONNEL MANAGEMENT OFFICERS. THIS RELATIONSHIP IS ESPECIALLY IMPORTANT WHEN RESERVE COMPONENT PERSONNEL ARE PROFILED.

(1) DETERMINATION OF INDIVIDUAL ASSIGNMENT OR DUTIES TO BE PERFORMED ARE COMMAND/ADMINISTRATIVE MATTERS. LIMITATIONS SUCH AS "NO FIELD DUTY," "NO OVERSEA DUTY," "MUST HAVE SEPARATE RATIONS," ARE NOT PROPER MEDICAL RECOMMENDATIONS.

(2) IT IS THE RESPONSIBILITY OF THE COMMANDER OR PERSONNEL MANAGEMENT OFFICER TO DETERMINE PROPER ASSIGNMENT AND DUTY, BASED UPON KNOWLEDGE OF THE SOLDIER'S PROFILE, ASSIGNMENT LIMITATIONS, AND THE DUTIES OF HIS OR HER GRADE AND MILITARY OCCUPATIONAL SPECIALTY (MOS).

(3) APPENDIX VIII CONTAINS THE PHYSICAL PROFILE CAPACITY GUIDE.

9-4. Modifier to Serial

To make a profile serial more informative, the modifier will be used as indicated below. These modifiers to the profile serial are not to be confused with code designation, indicating permanent limitation, as described in paragraph 9-5.

a. "*P*"—*Permanent*. This modifier indicates that the profile is permanent and change may only be made by authority designated in paragraph 9-6.

b. "*T*"—*Temporary*. This modifier indicates that the condition necessitating numerical designation "3" or "4" is considered temporary, the correction or treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. Individuals on active duty and Reserve Component members not on active duty with a "T" modifier will be medically evaluated at least once every 3 months with a view to revising the profile. In no case will individuals in military status carry a "T" modifier for more than 12 months without positive action being taken either to correct the defect or to effect other appropriate disposition. For Reserve Component members a determination involv-

ing entitlements to pay and allowances while disabled is an adjunct consideration. As a general rule, the physician initiating the "T" modifier will initiate appropriate arrangements for the necessary correction or treatment of the temporary condition.

c. *Records.* Whenever a temporary medical condition is recorded on the DA Form 3349 or SF 88 (Report of Medical Examination) or is referred to in a routine personnel action, the modifier "T" will be entered immediately following each PULHES numerical designator when a temporary condition exists.

9-5. Representative Profile Serial and Codes

To facilitate the assignment of individuals after they have been given a physical profile serial and for statistical purposes, the following code designations have been adopted to represent certain combinations of numerical designators in the various factors and most significant assignment limitations. The alphabetical coding system will be recorded on personnel qualification records. This coding system will not be used on medical records to identify limitations. The numerical designations under each profile factor, PULHES, are set forth in appendix VIII.

	<i>Description/assignment limitation</i>	<i>Medical criteria</i>
(1) Profile Serial 111111. CODE A	No assignment limitation. Is considered medically fit for initial assignment under all PULHES factors for Ranger, Airborne, Special Forces training, and training in any MOS.	No demonstrable anatomical or physiological impairment within standards established in appendix VIII.
(2) Profile serial within a "2" as the lowest numerical designator. CODE B	May have assignment limitations which are intended to protect against further physical damage/injury. Combat fit. May have minor impairment under one or more PULHES factors which disqualify for certain MOS training or assignment.	Minor loss of digits, minimal loss of joint motion, visual and hearing loss below those prescribed for Code A in appendix VIII.
(3) Profile serial with a "3" or "4" as the lowest numerical designator in any factor or as specified by a PPBD. CODE C	Possesses impairments which limit functions or assignments but within which the individual is capable of performing military duty. No crawling, stooping, running, jumping, marching, or standing for long periods. (State time permitted in item 8.)	 Vascular insufficiency; symptomatic flat feet; low back pathology; arthritis of low back or lower extremities.
CODE D	No mandatory strenuous physical activity. (State time in item 8.)	Organic cardiac disease; pulmonary insufficiency; hypertension, more than mild.
CODE E	No assignment to units requiring continued consumption of combat rations.	Endocrine disorders—recent or repeated peptic ulcer activity—chronic gastrointestinal disease requiring dietary management.
CODE F	No assignment to isolated areas where definitive medical care (US Armed Forces hospital) is not available.	Individuals who require continued medical supervision or periodic followup. Cases of established pathology likely to require frequent outpatient care or hospitalization.
CODE G	No assignment requiring handling of heavy materials including weapons (except individual weapon; e.g., rifle, pistol, carbine, etc.) No overhead work; no pullups or pushups. (State time permitted in item 8.)	Arthritis of the neck or joints of the upper extremities with restricted motion. Cervical disk disease; recurrent shoulder dislocation.
CODE H	No assignment where sudden loss of consciousness would be dangerous to self or others such as work on scaffolding, han-	Epileptic disorders (cerebral dysrhythmia) of any type; other disorders producing syncopal attacks or severe vertigo, such

Description/assignment limitation
dling ammunition, vehicle driving, work
near moving machinery.

Medical criteria
as Meniere's syndrome.

★ CODE J

1. No exposure to noise in excess of 85dBA or weapon firing without use of properly fitted hearing protection (to include firing for POR qualification or annual weapons qualification). Annual hearing test required.
2. Further exposure to noise is hazardous to health. No duty or assignment to noise levels in excess of 85dBA or weapon firing (not to include firing for POR qualification or annual weapons qualification with proper ear protection). Annual hearing test required.
3. No exposure to noise in excess of 85dBA or weapon firing without use of properly fitted hearing protection. This individual is "deaf" in one ear. Any permanent hearing loss in good ear will cause serious handicap. Annual hearing test required.
4. Further duty requiring exposure to high intensity noise is hazardous to health. No duty or assignment to noise levels in excess of 85dBA or weapon firing (not to include firing for POR qualification or annual weapons qualification with proper ear protection). No duty requiring acute hearing. A hearing aid must be worn to meet medical fitness standards.

Susceptibility to acoustic trauma.

CODE L

No assignment which requires daily exposure to extreme cold. (List specific time or areas in item 8.)

Documented history of cold injury; vascular insufficiency; collagen disease, with vascular or skin manifestations.

CODE M

No assignment requiring exposure to high environmental temperature. (List specific time or areas in item 8.)

History of heat stroke, history of skin malignancy or other chronic skin diseases which are aggravated by sunlight or high environmental temperatures.

Description/assignment limitation

Medical criteria

CODE N	No continuous wearing of combat boots. (State the length of time in item 8.)	Any vascular or skin condition of the feet or legs which, when aggravated by continuous wear of combat boots, tends to develop unfitting skin lesions.
CODE P	No continuous wearing of woolen clothes. (State the length of time in item 8.)	Established allergy to wool, moderate.
CODE U	Limitation not otherwise described, to be considered individually. (Briefly define limitation in item 8.)	Any significant functional assignment limitation not specifically identified elsewhere. Includes conditions described under Profile S-3.

(4) Profile serial with a "4" as the lowest numerical designator in any factor.

CODE V	<i>Department of Army Flag.</i> This code identifies the case of a member with a disease, injury, or medical defect which is below the prescribed medical criteria for retention who is continued in the military service pursuant to AR 140-120, AR 635-40, or predecessor directives. The numerical designation "4" will be inserted under the appropriate factor in all such cases. Such individuals generally have rigid and strict limitations as to duty, geographic, or climatic area utilization. In some instances the individual may have to be utilized only within close proximity to a medical facility capable of handling such cases.	Chapter 3, AR 40-501.
CODE W	<i>Waiver.</i> This code identifies the case of an individual with disease, injury, or medical defect which is below the prescribed medical criteria for retention who is accepted under the special provisions of chapter 8 or who is granted a waiver by direction of the Secretary of the Army. The numerical designation "4" will be inserted under the appropriate factor in all such cases. Such members generally have rigid and strict limitations as to duty, geographical, or climatic area utilization. In some instances the member may have to be utilized only within close proximity to a medical facility capable of handling such cases.	Chapters 3, 6, and 8, AR 40-501.
★CODE Y	<i>Fit for duty.</i> This code identifies the case of a member who has been determined to be fit for duty (not entitled to separation or retirement because of physical disability) after complete processing under AR 635-40, and has had his physical profile and appropriate assignment limitations determined by The Surgeon General.	

9-6. Profiling Officer

a. Commanders of Army medical treatment facilities (MTFs) are authorized to designate one or more physician(s), dentist(s), optometrist(s), podiatrist(s), audiologist(s), nurse practitioner(s), and physician assistant(s) as profiling officers. The commander will assure that those so designated are thoroughly familiar with the contents of these regulations. Profiling officer limitations are:

(1) *Physicians*. No limitations. Changing from or to a permanent numerical designator "3" or "4" requires a Physical Profile Board (PPBD) (para 9-8).

★(2) *Dentists, optometrists, podiatrists, audiologists, physical therapists, and occupational therapists*. No limitation within their specialty for awarding permanent numerical designators "1" and "2." Temporary numerical designator "3" may be awarded for a period not to exceed 30 days. Any extension of a temporary numerical designator "3" beyond 30 days must be confirmed by a physician. (The second member of the PPBD must always be a physician (see para 9-8).)

(3) *Physician assistants and nurse practitioners* are limited to awarding temporary numerical designators "1," "2" and "3" for a period not to exceed 30 days. Any extension of a temporary profile beyond 30 days must be confirmed by a physician. (Physician assistants and nurse practitioners will not be appointed as members of PPBDs.)

★(4) *Physicians (full-time or part-time civilian employees or fee-for-service physicians)* on duty at a MEPS will be designated profiling officers.

9-7. Recording and Reporting of Initial Physical Profile

a. Individuals accepted for initial appointment, enlistment or induction in peacetime normally will be given a numerical designator "1" or "2" physical profile in accordance with the instructions contained herein. Initial physical profiles will be recorded on Standard Form 88 (Report of Medical Examination) by the medical profiling officer at the time of the initial appointment, enlistment or induction medical examination.

9-6

b. The initial physical profile serial will be entered on SF 88 and also recorded on DD Form 47 (Record of Induction) or DD Form 1966 (Application for Enlistment—Armed Forces of the United States), in the items provided on these forms for this purpose. When modifier "T" or "P" is entered on the profile serial, or in those exceptional cases where numerical designator "3" or "4" is used on initial entry, a brief description of the defect expressed in nontechnical language will always be recorded in item 74, SF 88, in addition to the exact diagnosis required to be reported in summarizing the defects under item 74. All assignment, geographic or climatic area limitations, applicable to the defect recorded in item 74, will be entered in this item. If sufficient room for a full explanation is not available in item 74 of SF 88, proper reference will be made in that item and an additional sheet of paper will be added to SF 88.

c. Individuals who are found unacceptable under medical fitness standards of chapters 4, 5 or 7 will not be given a physical profile based on the provisions of those chapters. Profiling will be accomplished under the provisions of this chapter whenever such individuals are found to meet the medical procurement standards applicable at the time of examination.

9-8. Physical Profile Boards (PPBD)

a. *Physical profile boards will be appointed by the MTF commander* and will normally consist of two qualified physical profiling officers, one of whom must always be a physician. A third physical profiling officer may be appointed in complicated or controversial cases or to resolve disagreement between the members of a two-member board.

b. *Situations which require consideration of PPBD are—*

(1) Return to duty of a member hospitalized over 6 months. The board will insure that the patient has the correct physical profile, assignment limitation(s) and medical followup instructions, as appropriate.

(2) Permanent revision of a member's physical profile from or to a numerical designator "3" or "4" when, in the opinion of a profiling officer, the functional capacity of the individual has changed to the extent that it permanently alters

the individual's functional ability to perform duty.

(3) When an individual with a permanent numerical designator "2" under one or more PULHES factors requires significant assignment limitations. PPBD action is required in these cases because the profile serial "2" normally denotes a minor impairment requiring no significant limitation(s).

(4) When directed by the appointing authority in cases of a problematical or controversial nature requiring temporary revision of profile.

(5) Temporary request of the unit commander.

c. Temporary profiles. A temporary revision of profile will be accomplished when, in the opinion of the profiling officer, the functional capacity of the individual has changed to such an extent that it temporarily alters the individual's ability to perform duty. A profiling officer is authorized to issue a temporary profile without referring the case to the physical profile board or to the PPBD approving authority. Temporary profiles written on DA Form 3349 will not exceed 3 months. Temporary profiles written on DD Form 689 will not exceed 30 days.

★d. Individuals being returned to a duty status, pursuant to the approved finding of physically fit by a physical evaluation board, the Army Physical Disability Agency or the Army Physical Disability Appeal Board under AR 635-40, will be given a physical profile commensurate with their physical condition under the appropriate factors by The Surgeon General. Assignment limitations will be established concurrently. Records will be forwarded by the Commanding General, MILPERCEN to HQDA (SGPS-CP-B), Falls Church, VA 22041-3258, before notification of final action is returned to the medical facility having custody of the patient. After an appropriate period of time, such profile and limitations may be reviewed by a PPBD if the individual's functional capacity warrants such action. Changing of a designator "4" with a code V may be accomplished by a PPBD only with approval of MILPERCEN.

e. Tuberculous patients returned to a duty status who require antituberculous chemotherapy following hospitalization will be given a P-3-T profile for a period 1 year with recommendation that the member be placed on duty at a fixed installation and will be provided the required medical supervision for a period of 1 year.

f. The physical profile in controversial or equivocal cases may be verified or revised by a PPBD, hospital commander or command surgeon. Unusual cases may be referred to the Commanding General,

United States Army Health Services Command, for final determination of an appropriate profile.

g. Revision of the physical profile for reservists not on active duty will be accomplished by the ARCOM/GOCOM Staff Surgeons, Medical Corps Commander (O5 and higher) of USAR hospitals, or the Surgeon, RCPAC, without medical board procedure. For members of the Army National Guard not on active duty, such profile revision will be accomplished by the Surgeon, National Guard Bureau, the State surgeon or his designated medical officer. (See NGR 40-501.) Direct communication is authorized between units and the profiling authority, and in questionable cases with the Commanding General, United States Army Health Services Command. Revision of physical profile for Reserve Component members will be based on relationship to military duties. Secondary evidence concerning the civilian milieu may be considered by medical personnel in determining the effect of their recommendation upon Reserve Component soldiers. The profiling authority will use DA Form 3349.

h. Individuals whose period of service expires and whose physical profile code is "V," "W" or "Y" will appear before a medical board to determine if processing, as provided in AR 635-40, is indicated.

★i. Physical profile and assignment limitations as determined by medical evaluation board proceedings will take precedence over all previously issued temporary and permanent profiles awarded on DA Form 3349 in the soldier's medical records. Accordingly, medical board members must ensure that the physical profile and assignment limitations are fully recorded on DA Form 3349.

9-9. Profiling Pregnant Members

a. Intent. The intent of these provisions is to protect the fetus while ensuring productive utilization of the servicewoman. Common sense, good judgment and cooperation must prevail between policy, patient and patient's commander to ensure a viable program. (See TB MED 295.)

b. Responsibility.

(1) *Servicewoman.* Will seek medical confirmation of pregnancy. If pregnancy is confirmed, will comply with the instructions issued by medical personnel and her unit commander.

(2) *Medical personnel.* A physician will confirm pregnancy. If confirmed, will initiate prenatal care of the patient and issue a physical profile. Will ensure that the unit commander is provided a copy of

the profile. Will advise the unit commander as required.

(3) *Unit commander.* Will counsel all women as required by AR 635-100 or AR 635-200. Will consult with medical personnel as required.

c. Physical profiles.

(1) Profiles will be issued for the duration of the pregnancy. Profiles for members experiencing difficulty with the pregnancy will include additional limitations. Upon termination of pregnancy, a new profile will be issued reflecting revised profile information.

(2) Physical profile will be issued as follows:

(a) Under physical stamina indicate "T-3."

(b) List diagnosis as "pregnancy, estimated delivery date _____."

(c) Profile will indicate the following limitations:

1. Except under unusual circumstances, the member should not be reassigned (within CONUS, to or from oversea commands) until pregnancy is terminated. (See AR 614-30 for waiver provisions.)

2. Exempt from the regular PT program of the unit; physical fitness testing; exposure to chemical agents in NBC training; standing at parade rest or attention for longer than 15 minutes; all immunizations except influenza and tetanus-diphtheria; participating in weapons training, swimming qualifications, drown proofing and field training exercises when excused from wearing of the uniform by the unit commander.

3. No assignment to duties where nausea, easy fatigability or sudden lightheadedness would be hazardous to the woman or others, to include all aviation duty, Classes 1, 1A, 2, and 3. Class 2A, Air Traffic Control personnel, may continue ATC duties with approval of the flight surgeon, obstetrician and ATC supervisor.

4. May work shifts.

5. During the last 3 months of pregnancy, the woman must rest 20 minutes every 4 hours (sitting in a chair with feet up is acceptable). Her workweek should not exceed 40 hours; however, it does not preclude assignments as CQ and other like duties performed in a unit, to include normal housekeeping duties. (CQ is part of the 40-hour workweek.)

d. Performance of duty. A woman who is experiencing a normal pregnancy may continue to perform military duty until delivery. Only those women experiencing unusual and complicated problems

(e.g., pregnancy induced hypertension) will be excused from all duty, in which case they may be hospitalized or placed sick in quarters. Medical personnel will assist unit commanders in determining duties.

e. Sick in quarters. A pregnant woman will not be placed sick in quarters solely on the basis of her pregnancy unless there are complications present which would preclude any type of duty performance.

Convalescent leave. (As prescribed by AR 630-5.)

(1) Convalescent leave after delivery will be for a period determined by the attending physician.

(2) Convalescent leave after abortion will be determined on an individual case basis by the attending physician.

★ 9-10. Preparation, Approval and Disposition of DA Form 3349

a. Preparation of DA Forms 3349. (See fig 9-1.)

(1) DA Form 3349 will be used to record both permanent profiles and temporary profiles.

(2) DA Form 3349 will be prepared as follows:

(a) *Item 1.* Record medical condition(s) and/or physical defect(s) in common usage, nontechnical language which a layman can understand. For example, "compound comminuted fracture, left tibia" might simply be described as "broken leg."

(b) *Item 2.* Enter under each PULHES factor the appropriate profile serial code (1, 2, 3 or 4, as prescribed) and T (temporary) or P (permanent) prefix modifier. (Double profiling is not authorized. Double profiling is the placement of the numerical designator 2, 3 or 4 under the U, H, L, E or S factor and then placing the same designator under the "P" factor solely because it was awarded the other factor.)

(c) *Item 3.* Clearly state all assignment limitations. Code designations (defined in para 9-5) are limited to permanent profiles for administrative use only and are to be completed by the MTF before sending a copy to the MILPO. The patient administrator is responsible for ensuring that the profile form is properly completed.

(d) *Item 4.* Check the appropriate block. If the profile is temporary enter the expiration date.

(e) *Item 5.* Check each block for exercises that are appropriate for the individual to do. Exercises are listed on the reverse of the form for each reference.

Note: The individual can do all of the exercises checked.

(f) *Item 6.* Check all aerobic conditioning exercises the individual *can do*. The training heart rate will be assumed to be that determined by the directions in block 8 unless otherwise noted. If another training heart rate or training intensity is desired, note it here.

(g) *Item 7.* Check all functional activities the individual *can do*. If no values are listed in miles or pounds it will be assumed these are within the normal limitations of a healthy individual.

(h) *Item 9.* Any other activity that it is felt to be beneficial for the individual may be listed here. This space may also be used locally for location-specific activities.

(i) *Signatures.*

1 Permanent 3 profiles and permanent 2 profiles requiring major assignment limitation(s) require signatures of a minimum of two profiling officers. In exceptional cases as required in paragraph 9-8, a third member will also sign.

2 Temporary profiles not requiring major assignment limitations require only the signature of one profiling officer.

b. *Approval of the "positive profile" form.*

(1) The appropriate approval authority is the approval authority for all permanent profiles requiring a 3 numerical designator and all permanent profiles requiring a 2 numerical designator and major assignment limitations.

(2) If the approval authority does not concur with the Physical Profile Board (PPBD) recommendation, the PPBD findings will be returned to the PPBD for reconsideration. If the approving authority does not concur in the reconsidered PPBD findings, the case will be referred to a Medical Evaluation Board convened under the provisions of chapter 7, AR 40-3.

c. *Disposition of the "positive profile" form (permanent profiles) by the MTF.*

(1) Original and one copy to the unit commander.

(2) One copy to the MILPO.

(3) One copy to the member's health record.

(4) One copy to the clinic file.

d. *Disposition of the "positive profile" form (temporary profiles).*

(1) Original and one copy to the unit commander.

(2) Record the temporary profile in the member's health record.

(3) Only in cases involving pseudofolliculitis of the beard will the soldier be furnished a copy.

9-11. Assignment Restrictions, or Geographical or Climatic Area Limitations

Paragraph 7-13 establishes that personnel fit for continued military status are medically fit for duty on a worldwide basis. Assignment restrictions or geographical or climatic area limitations are contained in paragraph 9-5 and on the reverse of DA Form 3349. Policies applying to assignment restrictions or geographical or climatic limitations with physical profiles are as follows:

a. There are no assignment restrictions or geographical or climatic area limitations associated with a numerical designator "1." An individual with "1" under all factors is medically fit for any assignment, including training in Ranger or assignment in Airborne or Special Forces.

b. There are normally no geographic assignment limitations associated with a numerical designator "2." The numerical designator "2" in one or more factors of the physical profile serial indicates that the individual possesses some medical condition or physical defect which may impose some limitation on MOS classification and duty assignment.

c. There are usually significant assignment restrictions or geographical or climatic area limitations associated with a physical profile identified with one or more numerical designators "3."

d. There are always major assignment restrictions or geographical or climatic area limitations associated with a physical profile identified with one or more numerical designators "4."

e. In every instance, each medical condition or physical defect causing an assignment limitation will be identified in nontechnical language.

f. Assignment restrictions or geographical or climatic area limitations must be realistic and in accordance with accepted medical principles rather than based upon the personal beliefs or feelings of the profiling officer or the desires of the individual or the individual's family. Permanent limitations should be confirmed periodically, particularly in conjunction with inpatient or outpatient medical care and periodic medical examinations. (Every 4 years for Reserve Component personnel not on active duty in conjunction with their periodic medical examination.)

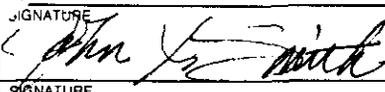
9-12. Responsibility for Personnel Actions

Unit commanders and personnel officers are responsible for necessary personnel actions, including appropriate entries on personnel management rec-

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ords and the assignment of the individual to military duties commensurate with the individual's physical profile and recorded assignment limitations. The unit commander's and MILPO copies of

the DA Form 3349 will be delivered by means other than the individual on whom the report is made. Only in cases involving *pseudofolliculitis of the beard* will the soldier be furnished a copy.

PHYSICAL PROFILE																																	
For use of this form, see AR 40-501; the proponent agency is the Office of The Surgeon General																																	
1. MEDICAL CONDITION Knee Pain		2. <table border="1" style="font-size: x-small; text-align: center;"> <tr><td>P</td><td>U</td><td>L</td><td>H</td><td>E</td><td>S</td></tr> <tr><td>1</td><td>1</td><td>T3</td><td>1</td><td>1</td><td>1</td></tr> </table>		P	U	L	H	E	S	1	1	T3	1	1	1																		
P	U	L	H	E	S																												
1	1	T3	1	1	1																												
3. ASSIGNMENT LIMITATIONS ARE AS FOLLOWS No running over one mile per hour. No deep knee bend activities.		CODES																															
4. THIS PROFILE IS <input type="checkbox"/> PERMANENT <input checked="" type="checkbox"/> TEMPORARY EXPIRATION DATE: 10 Jun 86																																	
5. THE ABOVE STATED MEDICAL CONDITION SHOULD NOT PREVENT THE INDIVIDUAL FROM DOING THE FOLLOWING ACTIVITIES																																	
<table style="width:100%; font-size: x-small;"> <tr> <td><input type="checkbox"/> Groin Stretch</td> <td><input type="checkbox"/> Thigh Stretch</td> <td><input type="checkbox"/> Lower Back Stretch</td> <td><input type="checkbox"/> Neck & Shoulder Stretch</td> <td><input type="checkbox"/> Neck Stretch</td> </tr> <tr> <td><input type="checkbox"/> Hip Raise</td> <td><input type="checkbox"/> Quads Stretch & Bal.</td> <td><input type="checkbox"/> Single Knee to Chest</td> <td><input type="checkbox"/> Upper Back Stretch</td> <td><input type="checkbox"/> Ankle Stretch</td> </tr> <tr> <td><input type="checkbox"/> Knee Bender</td> <td><input type="checkbox"/> Calf Stretch</td> <td><input type="checkbox"/> Straight Leg Raise</td> <td><input type="checkbox"/> Chest Stretch</td> <td><input type="checkbox"/> Hip Stretch</td> </tr> <tr> <td><input type="checkbox"/> Side-Straddle Hop</td> <td><input type="checkbox"/> Long Sit</td> <td><input type="checkbox"/> Elongation Stretch</td> <td><input type="checkbox"/> One-Arm Side Stretch</td> <td><input type="checkbox"/> Upper Body Wt Tng</td> </tr> <tr> <td><input type="checkbox"/> High Jumper</td> <td><input type="checkbox"/> Hamstring Stretch</td> <td><input type="checkbox"/> Turn and Bounce</td> <td><input type="checkbox"/> Two-Arm Side Stretch</td> <td><input type="checkbox"/> Lower Body Wt Tng</td> </tr> <tr> <td><input type="checkbox"/> Jogging in Place</td> <td><input type="checkbox"/> Hams. & Calf Stretch</td> <td><input type="checkbox"/> Turn and Bend</td> <td><input type="checkbox"/> Side Bender</td> <td><input type="checkbox"/> All</td> </tr> </table>				<input type="checkbox"/> Groin Stretch	<input type="checkbox"/> Thigh Stretch	<input type="checkbox"/> Lower Back Stretch	<input type="checkbox"/> Neck & Shoulder Stretch	<input type="checkbox"/> Neck Stretch	<input type="checkbox"/> Hip Raise	<input type="checkbox"/> Quads Stretch & Bal.	<input type="checkbox"/> Single Knee to Chest	<input type="checkbox"/> Upper Back Stretch	<input type="checkbox"/> Ankle Stretch	<input type="checkbox"/> Knee Bender	<input type="checkbox"/> Calf Stretch	<input type="checkbox"/> Straight Leg Raise	<input type="checkbox"/> Chest Stretch	<input type="checkbox"/> Hip Stretch	<input type="checkbox"/> Side-Straddle Hop	<input type="checkbox"/> Long Sit	<input type="checkbox"/> Elongation Stretch	<input type="checkbox"/> One-Arm Side Stretch	<input type="checkbox"/> Upper Body Wt Tng	<input type="checkbox"/> High Jumper	<input type="checkbox"/> Hamstring Stretch	<input type="checkbox"/> Turn and Bounce	<input type="checkbox"/> Two-Arm Side Stretch	<input type="checkbox"/> Lower Body Wt Tng	<input type="checkbox"/> Jogging in Place	<input type="checkbox"/> Hams. & Calf Stretch	<input type="checkbox"/> Turn and Bend	<input type="checkbox"/> Side Bender	<input type="checkbox"/> All
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<input type="checkbox"/> Jogging in Place	<input type="checkbox"/> Hams. & Calf Stretch	<input type="checkbox"/> Turn and Bend	<input type="checkbox"/> Side Bender	<input type="checkbox"/> All																													
6. AEROBIC CONDITIONING EXERCISES		7. FUNCTIONAL ACTIVITIES																															
<input checked="" type="checkbox"/> Walk at Own Pace and Distance <input type="checkbox"/> Run at Own Pace and Distance <input type="checkbox"/> Bicycle at Own Pace and Distance <input type="checkbox"/> Swim at Own Pace and Distance <input type="checkbox"/> Walk or Run in Pool at Own Pace <input type="checkbox"/> Unlimited Walking <input type="checkbox"/> Unlimited Running <input type="checkbox"/> Unlimited Bicycling <input checked="" type="checkbox"/> Unlimited Swimming <input type="checkbox"/> Run at Training Heart Rate for ___ Min. <input type="checkbox"/> Bicycle at Training Heart Rate for ___ Min. <input type="checkbox"/> Swim at Training Heart Rate for ___ Min.		<input type="checkbox"/> Wear Backpack (40 Lbs.) <input type="checkbox"/> Wear Helmet <input type="checkbox"/> Carry Rifle <input type="checkbox"/> Fire Rifle With Hearing Protection <input type="checkbox"/> KP/Mopping/Mowing Grass <input type="checkbox"/> Marching Up to ___ Miles <input type="checkbox"/> Lift Up to ___ Pounds <input checked="" type="checkbox"/> All PHYSICAL FITNESS TEST <input type="checkbox"/> Two Mile Run <input type="checkbox"/> Walk <input checked="" type="checkbox"/> Push-Ups <input type="checkbox"/> Swim <input checked="" type="checkbox"/> Sit-Ups <input type="checkbox"/> Bicycle																															
		8. TRAINING HEART RATE FORMULA																															
		MALES 220 FEMALES 225 MINUS (-) AGE MINUS (-) RESTING HEART RATE TIMES (x) % INTENSITY PLUS (+) RESTING HEART RATE 50% EXTREMELY POOR CONDITION 60% HEALTHY, SEDENTARY INDIVIDUAL 70% MODERATELY ACTIVE, MAINTENANCE 80% WELL TRAINED INDIVIDUAL																															
9. OTHER																																	
TYPED NAME AND GRADE OF PROFILING OFFICER John X. Smith, CPT, NC		SIGNATURE 	DATE 10 May 1986																														
TYPED NAME AND GRADE OF PROFIL		SIGNATURE	DATE																														
ACTION BY APPROVING AUTHORITY																																	
PERMANENT CHANGE OF PROFILE <input type="checkbox"/> APPROVED <input type="checkbox"/> NOT APPROVED																																	
TYPED NAME, GRADE & TITLE OF APPROVING AUTHORITY		SIGNATURE	DATE																														
ACTION BY UNIT COMMANDER																																	
THIS PERMANENT CHANGE IN PROFILE SERIAL <input type="checkbox"/> DOES <input type="checkbox"/> DOES NOT REQUIRE A CHANGE IN MEMBERS																																	
<input type="checkbox"/> MILITARY OCCUPATIONAL SPECIALTY <input type="checkbox"/> DUTY ASSIGNMENT BECAUSE:																																	
TYPED NAME AND GRADE OF UNIT COMMANDER		SIGNATURE	DATE																														
PATIENT'S IDENTIFICATION (For typed or written entries give Name last, first, middle; grade, SSN, hospital or medical facility)		UNIT																															
Jones, James Q. PFC 10 May 86 US Army Health Clinic, Ft. Ord		ISSUING CLINIC AND PHONE NUMBER Orthopedic Clinic 999-9999																															
		DISTRIBUTION UNIT COMMANDER - ORIGINAL & 1 COPY HEALTH RECORD JACKET - 1 COPY CLINIC FILE - 1 COPY MILPO - 1 COPY																															

DA FORM 3349, MAY 86

REPLACES DA FORM 5302-R (TEST) DATED FEB 84 AND DA FORM 3349 DATED 1 JUN 80, WHICH ARE OBSOLETE

Figure 9-1. Sample physical profile form.

 <p>GROIN STRETCH (BUTTERFLY)</p>	 <p>HAMSTRING STRETCH</p>	 <p>CHEST STRETCH</p>
 <p>HIP RAISE</p>	 <p>HAMSTRING AND CALF STRETCH</p>	 <p>ONE-ARM SIDE STRETCH</p>
 <p>KNEE BENDER</p>	 <p>LOWER BACK STRETCH</p>	 <p>TWO-ARM SIDE STRETCH</p>
 <p>SIDE-STRADDLE HOP</p>	 <p>SINGLE KNEE TO CHEST</p>	 <p>SIDE BENDER</p>
 <p>HIGH JUMPER</p>	 <p>SINGLE STRAIGHT LEG RAISE</p>	 <p>NECK STRETCH</p>
 <p>JOGGING IN PLACE</p>	 <p>ELONGATION STRETCH</p>	 <p>ANKLE STRETCH</p>
 <p>THIGH STRETCH</p>	 <p>TURN AND BOUNCE</p>	 <p>HIP STRETCH</p>
 <p>QUADS STRETCH AND BALANCE</p>	 <p>TURN AND BEND</p>	<p>UPPER BODY WEIGHT TRAINING (See FM 21-20)</p>
 <p>CALF STRETCH</p>	 <p>NECK AND SHOULDER STRETCH</p>	<p>LOWER BODY WEIGHT TRAINING (See FM 21-20)</p>
 <p>LONG SIT</p>	 <p>UPPER BACK STRETCH</p>	<p>FOR WRITTEN DESCRIPTION OF THESE EXERCISES SEE FM 21-20, AUGUST 1985</p>

REVERSE OF DA FORM 3349, MAY 86

Figure 9-2. Sample physical profile form—Continued

CHAPTER 10

MEDICAL EXAMINATIONS—ADMINISTRATIVE PROCEDURES

Section I. GENERAL PROVISIONS¹

10-1. Scope

This chapter provides—

a. General administrative policies relative to military medical examinations.

★*b.* Requirements for periodic, separation, mobilization, and other medical examinations.

c. Policies relative to hospitalization of examinees for diagnostic purposes and use of documentary medical evidence, consultations, and the individual health record.

d. Policies relative to the scope and recording of medical examinations accomplished for stated purposes.

10-2. Applicability

The provisions contained in this chapter apply to all medical examinations accomplished at US Army medical facilities or accomplished for the US Army.

★10-3. Physical Fitness

Maintenance of physical and medical fitness is an individual military responsibility, particularly with reference to preventable conditions and remediable defects. Each member has a definite obligation to maintain him- or herself in a state of good physical condition in order that he or she may perform his or her duties efficiently. Each individual, therefore, should seek timely medical advice whenever he or she has reason to believe that he or she has a medical condition or a physical defect which affects, or is likely to affect, his or her physical or mental well-being. He or she should not wait until the time of his or her periodic medical examination to make such a condition or defect known. The medical examinations

prescribed in this regulation can be of material assistance in this regard by providing a means of determining the existence of conditions requiring attention. Commanders will bring this matter to the attention of all members during initial orientation and periodically throughout their period of service. In addition, medical examiners will counsel members as part of the periodic medical examination.

10-4. Consultations

a. The use of specialty consultants, either military or civilian, for the accomplishment of consultations necessary to determine an examinee's medical fitness is authorized in AR 40-3 and AR 601-270.

b. A consultation will be accomplished in the case of an individual being considered for military service, including USMA and ROTC, whenever—

(1) Verification, or establishment, of the exact nature or degree of a given medical condition or physical defect is necessary for the determination of the examinee's medical acceptability or unacceptability based on prescribed medical fitness standards, or

(2) It will assist higher headquarters in the review and resolution of a questionable or borderline case, or

(3) It is prescribed in chapter 11, or

(4) The examining physician deems it necessary.

c. A consultation will be accomplished in the case of an individual on active duty as outlined in *a* above or whenever it is indicated to insure the proper professional care and disposition of the servicemember.

d. A consultation will be accomplished by a physician, either civilian or military, qualified therefor by training in or by a practice devoted primarily to the specialty. In some instances, a physician who practices in another specialty may be considered qualified by virtue of the nature of

¹Provisions of this chapter which apply to civilian aviation personnel flying Army aircraft have been reviewed by the Federal Aviation Administration (FAA). Should FAA requirements change from, or conflict with, requirements stated in this regulation (e.g., frequency of examination for ATC duty), FAA policy will prevail.

that specialty and its relationship to the specialty required.

e. A medical examiner requesting a consultation will routinely furnish the consultant with—

(1) The purpose or reason for which the individual is being examined; for example, induction.

(2) The reason for the consultation; for example, persistent tachycardia.

(3) A brief statement on what is desired of the consultant.

(4) Pertinent extracts from available medical records.

(5) Any other information which will assist the consultant in the accomplishment of the consultation.

f. Reports of consultation will be appended to Standard Form 88 (Report of Medical Examination) as outlined in paragraph 10-5.

g. A guide as to the types and minimum scopes of the more frequently required consultations is contained in appendix IX.

10-5. Distribution of Medical Reports

A minimum of two copies (both signed) of SF 88 and SF 93 (Report of Medical History) (when required) will be prepared. One copy of each will be retained by the examining facility and disposed of in accordance with AR 340-18-9. The other copy will be filed as a permanent record in the health record (AR 40-66) or comparable permanent file for nonmilitary personnel. Special instructions for preparation and distribution of additional copies are contained elsewhere in this chapter or in other regulations dealing with programs involving or requiring medical examinations. Copies may be reproduced from signed copies by any duplicating process which produces legible and permanent copies. Such copies are acceptable for any purpose unless specifically prohibited by the applicable regulation. Distribution of copies will not be made to unauthorized personnel or agencies.

10-6. Documentary Medical Evidence

a. Documentary medical records and other documents prepared by physicians or other individuals may be submitted by, or in behalf of, an examinee as evidence of the presence, absence, or treatment of a defect or disease, and will be

given due consideration by the examiner(s). Submission and use of such documentary medical evidence is encouraged. If insufficient copies are received, copies will be reproduced to meet the needs of *b* and *c* below.

b. A copy of each piece of documentary medical evidence received will be appended to *each* copy of the SF 88 and a statement to this effect made in item 73, except as prescribed in *c* below.

c. When a report of consultation or special test is obtained for an examinee, a copy will be attached to each SF 88 as an integral part of the medical report, and a statement to this effect will be made in item 73 and cross-referenced by the pertinent item number.

10-7. Facilities and Examiners

★a. For the purpose of this regulation, a physician is defined as any individual who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures in the area concerned. Any individual so qualified may perform medical examinations of any type except where a specific requirement exists for the examination to be conducted by a physician qualified in a specialty. Dentists, physician assistants, nurse practitioners, optometrists, audiologists, podiatrists, and civilian employees, properly qualified by appropriate training and experience, may accomplish such phases of the medical examination as are deemed appropriate by the examining physician. They may sign the SF 88 for the portions of the examination they actually accomplish but the supervising physician will sign the SF 88 and SF 93 in all cases.

★b. In general, medical examinations conducted for the Army will be accomplished at facilities of the Armed Forces, using military medical officers on Active or Reserve duty, or full-time or part-time civilian employee physicians, with the assistance of dentists, physician assistants, nurse practitioners, optometrists, audiologists and podiatrists.

★c. Medical examinations for aviation applicants and aviation personnel will be accomplished as follows:

(1) For entrance into Army aviation pilot training (Class 1, 1A or 2), and entrance into primary courses in aviation medicine (Class 2), exam-

inations will be accomplished only at Active or Reserve facilities of the Armed Forces, by or under the immediate supervision of an assigned or attached flight surgeon. (Applicability of Class 1 and 1A standards will be in accordance with AR 611-110.) Medical Corps officers or civilian employee physicians, who by training or experience have been previously designated military flight surgeons or military aviation medicine officers but who at the time of examination are performing duty in a specialty other than aviation medicine, are considered to be flight surgeons for this purpose and may accomplish these examinations. Other physicians, dentists, physician assistants, nurse practitioners, optometrists, audiologists and podiatrists may sign the SF 88 for the portions of the examination they actually accomplish but the supervising flight surgeon must, as a minimum, conduct the ARMA examination, review the SF 88, SF 93 and allied papers, and sign the SF 88 and SF 93 in all cases. FAA Medical Certificate Second Class examination for entry into training and continuance on duty as an air traffic controller (Class 2A) will be accomplished by a military flight surgeon if one is available within 60-minute travel time (one way); if not, by a civilian aviation medical examiner designated by the Federal Aviation Administration to administer examinations for FAA Medical Certificates Second Class. Funding will be in accordance with paragraph 10-7g below.

(2) Medical examinations for entrance into training as aviation mechanics, crew chiefs, observers, door gunners, or other Class 3 duties will be accomplished by a flight surgeon if one is available within 60-minute travel time (one way); if not, by any physician assigned or attached to an Active or Reserve military facility. They will then be reviewed and signed by a flight surgeon.

(3) Medical examinations for continuance of aviation duty (Classes 2, 2A, and 3) (military members) will be accomplished by a flight surgeon, if available within 60-minute travel time (one way), or may otherwise be accomplished by any physician assigned or attached to any Active or Reserve military facility. All Classes 2, 2A, and 3 examinations will be reviewed and signed by a flight surgeon. Active duty aviators on MAAG or exchange tours may be examined by host

country flight surgeons if US military flight surgeons are not available. SF 88 and SF 93 will be used. Allied documents may be host country forms if US forms are not available. Army National Guard and Army Reserve members not on active duty may be examined by Medical Corps officers of either the Active or Reserve Component of the Army, Navy or Air Force. In the case of Classes 2, 2A, and 3 continuance, Active and Reserve Component personnel who are not located within 60-minute travel time of an Active or Reserve military facility, may be authorized by their commander to obtain their Army Class 2 (aviators), Army Class 3 or FAA Second Class (ATC) examination from civilian FAA-designated aviation medical examiners (AMEs). SF 88 and SF 93 must be used for Class 2 (aviators) and Class 3 examinations. Allied documents will preferably be US Government forms (DA, DOD, SF). Funding will be as in paragraph 10-7g below. AMEs who are former military flight surgeons will be utilized when available. In cases where civilian AMEs are utilized for Class 2 or Class 3 Reserve examinations, a Reserve Component flight surgeon from a State (ARNG) or an area command (USAR) must review and sign the SF 88 as the reviewing official. Such use of civilian AMEs is authorized only when the reviewing flight surgeon has determined that the scope, content and accuracy of flying duty medical examinations done by specific civilian AMEs are at least equivalent to Army standards of quality. See paragraph 10-26k for examination of civilians and for FAA certification.

d. The periodic medical examination, required by AR 635-40 in the case of an individual who is on the Temporary Disability Retired List, will be accomplished at a medical treatment facility designated by Headquarters, Department of the Army.

e. Medical examinations for qualification and admission to the United States Military Academy, the United States Naval Academy, the United States Air Force Academy, and the respective preparatory schools will be conducted at medical facilities specifically designated in the annual catalogs of the respective academies.

f. Medical examinations for ARNG and USAR purposes will be conducted by medical officers or

civilian physicians at medical facilities in the order of priority specified in AR 140-120 or NGR 40-501, as appropriate.

g. Additional tests, procedures, or consultations, that are necessary to supplement a medical examination, normally will be accomplished at a medical facility (including a MEPS) designated by the commander of the facility requesting the supplemental medical examination. Only on the authority of that commander will supplementary examinations be obtained from civilian medical sources. Funds available to the requesting commander will be used for payment of the civilian medical services he or she authorized.

10-8. Hospitalization

Whenever hospitalization is necessary for evaluation in connection with a medical examination, it may be furnished as authorized in AR 40-3 in the following priority:

- a.* Army medical treatment facilities.
- b.* Air Force and Navy medical treatment facilities.
- c.* Medical treatment facilities of other Federal agencies.
- d.* Civilian medical treatment facilities.

10-9. Medical Examination Techniques

(See chap 11.)

10-10. Objectives of Medical Examinations

The objectives of military medical examinations are to provide information—

- a.* On the health of the individual.
- b.* Needed to initiate treatment of illness.
- c.* To meet administrative and legal requirements.

10-11. Recording of Medical Examinations

The results of a medical examination will be recorded on SF 88, SF 93, and such other forms as may be required. See appendix IX and paragraph 10-14 for administrative procedures for filling out SF 88.

10-12. Remediable Medical Conditions and Physical Defects

When a medical examination reveals that an in-

dividual of the military service has developed a remediable defect during the course of his duties, he will be offered the opportunity of medical care if such is medically indicated. Determinations regarding corrective care for such conditions will be governed by the provisions of AR 600-9 and paragraph 48, AR 600-20. For US Army Reserve members, see AR 140-120 and for ARNG, see NGR 40-501.

10-13. Scope of Medical Examinations

a. The scope of a medical examination, Type A or B, is prescribed in appendix IX and will conform to the intended use of the examination.

b. Limited or screening examinations, special tests, or inspections required for specific purposes and which do not reflect the scope of a Type A or B examination are prescribed by other regulations. Such examinations, tests, and inspections falling outside the evaluative purposes of this chapter include those for drivers, personnel exposed to industrial or occupation hazards, tuberculin and Schick tests administered in the absence of illness, blood donors, chest X-ray surveys, food handlers, barbers, and others.

10-14. Standard Form 88 (Report of Medical Examination)

a. Each abnormality, whether or not it affects the examinee's medical fitness to perform military duty, will be routinely described and made a matter of record whenever discovered. The part or parts of the body will be specified whenever the findings (diagnoses) are not sufficient to localize the condition. (Manifestations or symptoms of a condition will not be used in lieu of a diagnosis.)

★*b.* Only those abbreviations authorized by AR 40-66 may be used.

c. Medical examiners will not routinely make recommendations for waivers for individuals who do not meet prescribed medical fitness standards. However, if a waiver is requested by the examinee, each disqualifying defect or condition will be fully described and a statement included as to whether the defect or condition—

- (1) Is progressive.
- (2) Is subject to aggravation by military service.

(3) Precludes satisfactory completion of prescribed training and subsequent military service.

(4) Constitutes an undue hazard to the individual or to others in the military environment. Such information will facilitate evaluation and determination by higher authority in acting upon waiver requests. In addition, a notation will be made listing any assignment limitations which would have to be considered in view of the described defect(s). Such notation is not required in waiver cases where the individual obviously is not medically fit, even under the criteria for mobilization outlined in chapter 6.

d. When feasible, an adequate review of the Report of Medical Examination, to include review of the health record, if available, will be performed and is the responsibility of the commander of the medical facility at which the examination is accomplished. Review by a field grade or senior company grade medical officer is desirable if circumstances permit. This review will be indicated by signature in item 82, SF 88.

e. The scopes of Types A and B medical examinations and instructions for recording the examinations on SF 88 are in appendix IX. Administrative data entered in items 1 through 17 will be typewritten or printed in ink. Whenever possible, trained clerical personnel will perform this function.

10-15. Standard Form 93 (Report of Medical History)

★*a. Standard Form 93.* SF 93 is prepared by the examinee prior to being examined. It provides the examining physician with an indication of the need for special discussion with the examinee and the areas in which detailed examination, special tests or consultation referral may be indicated. It is important that the questions on the form be answered spontaneously by the examinee. Completeness of all answers and comments is essential to the usefulness and value of the form. The information entered on this form is considered confidential and will not be released to unauthorized sources. The examinee should be apprised of the confidential nature of his or her entries and comments. Trained enlisted medical service personnel and qualified civilians may be used to instruct and assist examinees in

the preparation of the report but will make no entries on the form other than the information required in items 6 (date of examination) and 7 (examining facility or examiner, and address). Any help given the examinee will be only as an aid in his or her understanding of the question, not as suggested answers. A Spanish version (Historia Medica) is available for use by Spanish speaking examinees. SF 93 will normally be prepared in an original and one copy. Interleaved carbon paper may be used if forms are carefully aligned and the carbon copy is legible. The form will be prepared in all instances indicated in paragraph 10-16 and whenever: (1) Required by some other directive, (2) considered desirable by the examining physician, (3) directed by Headquarters, Department of the Army, or (4) when required by the reviewing agency.

b. Identification and administrative data. Items 1 through 7 will be typewritten or printed in ink. Whenever possible, trained clerical personnel will perform this function.

c. Medical history and health data.

(1) *Item 8.* A brief statement by the examinee expressing his opinion of his or her present state of health. If unsatisfactory health is indicated in generalized terms such as "fair" or "poor," the examinee will elaborate briefly to include pertinent information of his or her past medical history.

(2) *Examinee's medical history.* This includes items 9 through 25:

(*a.*) *Items 9 and 11* provide a means of determining the examinee's state of health, past and present, and possibly identifying medical conditions which should be evaluated in the course of the medical examination. The examinee will complete all items by checking "yes" or "no" for each.

(*b.*) *Item 12* will be completed by all female examinees.

(*c.*) *Items 13 and 14* will be completed by each examinee. Students who have not had full-time employment will enter the word "student" in item 13. Members of the Active Army who had no full-time employment prior to military service will enter "soldier" or "Army officer" as appropriate in item 13.

(*d.*) *Items 15 through 24.* These questions and the answers are concerned with certain

other environmental and medical conditions which can contribute to the physician's evaluation of the examinee's present and future state of health. All answers checked "yes" will be fully explained by the examinee to include dates, locations, and circumstances. The examinee will sign the form in black or dark-blue ink.

d. Physician's summary and elaboration of examinee's medical history.

(1) The physician will summarize and elaborate upon the examinee's medical history as revealed in items 8 through 24 and in the case of military personnel, the examinee's health record, cross-referencing his or her comments by item number. All items checked in the affirmative will be clarified and the examiner will fully describe all abnormalities including those of a nondisqualifying nature. This information is needed to assist in evaluating the examinee's background and to protect the individual and the Government in the event of future claims for disability or aggravation of disability.

(2) If the examinee's answers reveal that he or she was previously rejected for military service (item 22) or was discharged for medical reasons (item 23), the exact reasons should be ascertained and recorded. Such examinees, if found medically fit, will be considered of "doubtful acceptability" until such time as the cause for previous rejection or discharge has been thoroughly reviewed and evaluated (para 4-22b, AR 601-270).

(3) Rubber stamps will not be used to elaborate nor will a facsimile stamp be used for signature. The typed or printed name of the physician and date will be entered in the designated blocks. The physician will sign in black or dark-blue ink.

10-16. Types of Medical Examinations

a. General. There are two general types of medical examinations, Type A and Type B, which meet the requirements for evaluation of individuals for most purposes. The scope of each of these examinations is indicated in appendix IX. Additional examination to extend or complement a Type A or Type B medical examination is appropriate when indicated or directed to permit use of the examination for special purposes.

b. Type A medical examination. A Type A medical examination is required to determine medical fitness of personnel under the circumstances enumerated below. SF 93 must be prepared in all cases except as indicated by an asterisk (*).

- (1) Active duty.
- (2) Active duty for training for more than 30 days.
- (3) *Airborne, Ranger, and Special Forces.
- (4) Allied and foreign military personnel.
- (5) Appointment as a commissioned or warrant officer regardless of component.
- (6) *Army service schools, except Army aviation and Marine diving.
- (7) Deserters who return to military control, except those being administratively discharged under the provisions of chapter 10 or section V, chapter 14 of AR 635-200.
- ★(8) Enlistment (initial).
- ★(9) Reenlistment.
 - (a) Immediate reenlistment (no break in service). A medical examination is not required.
 - (b) Reenlistment (with a break in service). A medical examination is required unless there is a copy of a report of medical examination for separation that was accomplished within the 1-year validity period prescribed by paragraph 10-17, or medical information contained on DA Form 1811 (Physical Data and Aptitude Test Scores Upon Release From Active Duty) if reenlisting within 6 months of release from active duty.
- (10) *General prisoners when prescribed.
- (11) Induction and preinduction.
- (12) *Medical board processing except when done solely for profiling.
- (13) Military Advisory Assistance Group, Army Attaché, Military Mission assignment, and assignment to isolated areas where adequate US military medical care is not readily available.
- (14) Officer Candidate School.
- (15) *Oversea duty when prescribed except as outlined under Type B medical examination.
- (16) Periodic for Army Reserve Components.
- (17) *Periodic for Active Duty members, other than Army aviation and diving.
- (18) Prisoners of war, when required, internees and repatriates.

(19) ROTC. Enrollment in ROTC, all levels except for enrollment in the Four-year Scholarship Program which requires a Type B examination.

(20) Separation, resignation, retirement and relief from active duty, if accomplished. (SF 93 is not required in connection with separation examination for immediate recruitment.)

(21) Free fall parachuting. (SF 93 required for initial selection only.)

(22) Marine (SCUBA) diving (Special forces and ranger combat diving). (SF 93 required for initial selection only.)

c. Type B medical examination. A Type B medical examination is required to determine the medical fitness of personnel under the circumstances enumerated below. SF 93 will be prepared except as noted.

(1) Army aviation including selection, continuance, or periodic annual medical examination: Pilot, aircraft mechanic, air traffic controller, flight simulator specialist, or participant in frequent or regular flights as nondesignated or non-rated personnel not engaged in the actual control of aircraft, such as gunners, observers, etc. (SF 93 required for all Classes 1 and 1A examinations.)

(2) Marine diving (MOS 00B), including selection, continuance or periodic annual medical examination. (SF 93 required for initial selection only.) (For periodic examinations, individual health record and DA Form 3475-R (Diving Duty Summary Sheet) must be available to the examiner.)

(3) US Air Force Academy.

(4) US Air Force Academy Preparatory School.

(5) US Military Academy.

(6) US Military Academy Preparatory School.

(7) US Naval Academy.

(8) US Naval Academy Preparatory School.

(9) Four-year ROTC Scholarship.

(10) Entrance into the Uniformed Services University of the Health Sciences.

10-17. Validity—Reports of Medical Examination

a. Medical examinations will be valid for the purpose and within the periods set forth below, provided there has been no significant change in the individual's medical condition.

(1) Two years from date of medical examination for entrance into the United States Military Academy, the Uniformed Services University of Health Sciences, and the ROTC Scholarship Program. (This period may be modified to any period

less than 2 years, and reexamination required as determined by the Director, Department of Defense Medical Examination Review Board (DODMERB).)

★(2) Eighteen months from the date of medical examination to qualify for induction, enlistment, reenlistment, or appointment as a commissioned officer or warrant officer, for active duty, active duty for training, advanced ROTC, OCS, admission to USMA Preparatory School, entry into training for aviation Classes 1, 1A, 2, and 3, or diving and free fall parachuting. (Medical examinations administered to ROTC cadets at Advanced Camp are valid for 18 months from date of examination for continuance in ROTC appointment as a commissioned officer, and entrance on active duty or active duty for training.)

(3) Approximately 1 year from date of examination (FAA Second Class) to qualify for entry into training for Air Traffic Control duties. These examinations are valid for the remainder of the month in which the examination was taken plus the next 12 calendar months, as specified in Federal Air Regulations.

(4) When accomplished incident to retirement, discharge or release from active duty, medical examinations are valid for a period of 1 year from date of examination. If the examination is accomplished more than 4 months prior to retirement, discharge or release from active duty, DA Form 3081-R (Periodic Medical Examination (State of Exemption)) will be attached to the original SF 88. (See also para 10-25.) DA Form 3081-R (fig 10-1) will be reproduced locally on 8- by 10½-inch paper. The form number, title, and date should appear on each reproduced copy.

(Locate fig 10-1, a fold-in page, at the end of the regular size pages.)

(5) Three months from date of Secretarial approval for reentry into the Army of members on the TDRL who have been found physically fit.

b. Except for flying duty, discharge or release from active duty, a medical examination conducted for one purpose is valid for any other purpose within the prescribed validity periods, provided the examination is of the proper scope specified in this chapter. If the examination is deficient in scope, only those tests and procedures needed to meet additional requirements need be accomplished and results recorded.

c. The periodic examination obtained from members of the Army National Guard and Army Re-

serve (para 10-23) within the past 4 years will be valid for the purpose of qualifying for immediate reenlistment in the Army National Guard and Army Reserve of personnel not on active duty, provided there has been no change in the individual's medical condition since his or her last complete medical examination.

d. Army National Guard and Army Reserve members enlisted in the Alternate (Split) Training enlistment option. The validity period for medical examinations accomplished for enlistment, entry and reentry on active duty for training may be extended to 18 months as follows:

Prior to departure for the training installation for Phase II, members must undergo a physical inspection of the scope prescribed by AR 601-270. For ARNG members who do not process through a MEPS, the physical inspection must be accomplished by ARNG Medical Corps officers or civilian physicians. All ARNG and USAR members arriving at the training installations must have in their possession their military health record containing the initial Report of Medical Examination (SF 88) properly annotated by the physician who accomplished the physical inspection.

Section II. PROCUREMENT MEDICAL EXAMINATIONS

10-18. Procurement Medical Examinations

For administrative procedures pertaining to procurement medical examinations (para 2-1) conducted at military enlistment processing stations (MEPSs) see AR 601-270. For procedures pertain-

ing to appointment and enlistment in the Army National Guard and Army Reserve, see AR 140-120 and NGR 40-501. For procedures pertaining to enrollment in the Army ROTC, see AR 145-1.

Section III. RETENTION AND SEPARATION MEDICAL EXAMINATIONS

10-19. General

This section sets forth administrative procedures applicable to retention (including periodic medical examinations) and separation medical examinations (para 3-1).

(2) He or she alleges medical unfitness or disability.

c. Evaluation of medical fitness will be based on the medical fitness standards contained in chapter 3.

10-20. Active Duty For Training and Inactive Duty Training

a. Individuals on active duty for 30 days or less and those ordered to active duty for training without their consent under the provisions of AR 135-91 are not routinely required to undergo medical examination prior to separation. A medical examination will be given when—

(1) The individual has been hospitalized for an illness or an injury which may result in disability, or

(2) Sound medical judgment indicates the desirability of a separation medical examination, or

(3) The individual alleges medical unfitness or disability at the time of completion of active duty for training, or

(4) The individual requests a separation examination.

b. An individual on active duty training will be given a medical examination if—

(1) He or she incurs an injury during such training which may result in disability, or

10-21. Health Records

a. Medical examiners will review the health record (AR 40-66) of each examinee whenever an examination is conducted for the purpose of relief from active duty, relief from active duty for training, resignation, retirement, separation from the service, or when accomplished in connection with a periodic medical examination. The examinee's medical history as recorded in the health record is an important part of the physician's total evaluation. Health records include a medical evaluation and summary of each medical condition treated which is of clinical importance and materially affects the health of the individual. If the health record is not available (e.g., lost records, civilian examinees, Reserve Component personnel), an SF 93 will be accomplished.

b. In the accomplishment of medical examinations conducted under the provisions of this regulation for purposes other than those noted above, the health records of examinees should be reviewed by the examiner whenever such records are available.

10-22. Mobilization of Units and Members of the Reserve Components of the Army

Members of ARNGUS and USAR will be given medical examinations every 4 years as prescribed in AR 140-120 and NGR 40-501 (10 U.S.C. 1004). Medical examinations incident to mobilization are not required.

10-23. Periodic Medical Examinations

a. Application and scope.

(1) The periodic medical examination is required for all officers, warrant officers and enlisted personnel of the Army regardless of component. Individuals undergoing this examination should assist the physician by a frank and complete discussion of their past and present health, which, combined with appropriate medical examinations and clinical tests, will usually be adequate to determine any indicated measures or remedies. The purpose of the periodic medical examination is to assist in the maintenance of health. (In the event of mobilization, except for Class 2, aviators, and Class 2A, air traffic controllers, all periodic medical examinations prescribed by this paragraph for Active Army members are suspended.)

(2) Retired personnel are authorized, but not required, to undergo a periodic medical examination. They will make advance arrangements with the medical examining station before reporting for such examination (DA Pam 600-5).

(3) Other than required medical surveillance, the periodic medical examination is not required for an individual who has undergone or is scheduled to undergo, within 1 year, a medical examination, the scope of which is equal to or greater than that of the required periodic medical examination. The member will be furnished DA Form 3081-R (Periodic Medical Examination (Statement of Exemption)) who will prepare it and submit it to the unit commander or personnel officer for appropriate action. DA Form 3081-R (fig 10-1) will be reproduced locally on 8- by 10½-inch paper.

(4) The examining physician will thoroughly investigate the examinee's current medical status. When medical history, the examinee's complaints, or review of any available past medical records indicate significant findings, these findings will be described in detail, using SF 507 (Clinical Record—Report on or Continuation of SF), if necessary. If, as a result of the personal discussion of health between the medical officer and the examinee, it appears that there has been a change in the functional capacity of any com-

ponent of the physical profile serial, the medical officer will recommend a change in the serial in accordance with chapter 9.

(5) Members will be found qualified for retention on active duty if they meet the requirements of chapters 1 and 3. Special attention is directed to paragraphs 1-4 and 3-3 in this regard.

(6) Members who appear to be medically unfit will be referred to a medical board (AR 40-3).

(7) All reports of periodic medical examinations will be reviewed by a physician designated by the medical treatment facility commander. (Those administered by a MEPS will be reviewed by the chief medical officer.) The review will be accomplished in the following manner:

(a) The individual health record and the SF 88 will be reviewed in the presence of the examinee during which the reviewing physician will counsel the examinee regarding—

1. Remedial conditions found upon examination (appointments will be made for the purpose of instituting care).

2. Continuing care for conditions already under treatment.

3. General health education matters including, but not limited to, smoking, alcohol and drug abuse, sexual behavior, overweight or underweight and methods for correction.

(b) When the review is completed, and there is a need to change the member's physical profile and/or assignment limitations, DA Form 3349 (Medical Condition—Physical Profile Record) will be prepared and distributed as prescribed in chapter 9 of this regulation. SF 88 or extracts of the individual health record will not be released to the unit commander or personnel officer.

(8) The medical examination for general officers and full colonels should be performed on an individual appointment basis. The duplicate report (SF 88) in the case of each general officer will be forwarded by the examining facility direct to HQDA (DAPE-GO), WASH DC 20310-2300. In the case of each full colonel, the duplicate SF 88 will be forwarded by the examining facility direct to HQDA (DAPC-MSR), Alexandria, VA 22332-4000 for file in the individual's official military personnel file (OMPF).

★(9) In addition to the periodic medical examination prescribed by paragraph c(2) below, all women in the Army, regardless of age, on active duty or active duty for training tours in excess of 1 year will undergo two annual breast and pelvic examinations, to include a Papanicolaou cancer detec-

tion test, following initial entry on active duty. At age 25, and annually thereafter, this special examination is mandatory and will be accomplished during the anniversary month of the individual's birthday, and should be conducted by a qualified specialist whenever possible. A record of the examination and test results will be maintained in the health record. At age 35, all women in the Army on active duty or active duty for training tours in excess of 1 year will have a baseline mammographic study. At and after age 40, the study will be repeated annually in conjunction with the annual Papanicolaou cancer detection test. A record of the examination and test results will be maintained in the health record.

(10) All personnel with potential hazardous exposures in their work environment, for which medical surveillance examinations are required to insure that there is no harmful effect to their health, will receive appropriate medical surveillance examinations. Such examinations will be specific to job exposure.

b. Followup. A member of the ARNGUS or USAR who is not on active duty will be scheduled for followup appointment and consultations at Government expense when necessary to complete the examination. Treatment or correction of conditions or remediable defects as a result of examination will be scheduled if authorized. If the individual is not authorized treatment, he or she will be advised to consult a private physician of his or her own choice at his or her own expense.

c. Frequency.

(1) *General officers.*

(a) All general officers on active duty will undergo an annual medical examination within 3 calendar months before the end of the birthday month (Type B for those who are aviators, Type A for all others). In addition to the scope of the examination prescribed by appendix IX, the cardiovascular screening prescribed by paragraph 10-31 will be accomplished. Examinations will be scheduled on an individual appointment basis and accomplished on an outpatient or inpatient basis, depending upon the professional judgment of the examining physician(s). Additional test and/or diagnostic procedures in excess of the prescribed scope of the examination will be accomplished when, in the opinion of the examining physician(s), such procedures are indicated.

(b) The annual dental examination prescribed by AR 40-3 will, as far as practicable, also be accomplished.

(c) Immunization records will be reviewed and required immunizations will be administered

(AR 40-562).

(2) *Rated aviators and flight surgeons.*

(a) Rated aviators and flight surgeons, Active and Reserve Components who meet and continue to work under Class 2 medical fitness standards for flying (including rated aviators qualified for aviation service but not assigned to operational flying duty positions) must undergo a periodic Type B medical examination at ages 19, 21, 23, 25, 27, 29, 31, 33, 35 and annually thereafter.

(b) During the years when a Type B examination is not required because of age, each rated aviator and flight surgeon will undergo an eye examination; blood pressure, height, weight and hematocrit measurement; audiometric test and electrocardiogram. The results of these will be recorded on DA Form 4497-R (Interim Medical Examination—Aviation, Free Fall Parachuting and Marine (SCUBA) Diving Personnel). DA Form 4497-R (fig 10-3) will be reproduced locally on 8½- by 11-inch paper.

**(Locate fig 10-3, a fold-in page,
at the end of the regular size pages.)**

(c) Each Active Component aviator or flight surgeon must take the examinations cited in (a) and (b) above within the 3-month period preceding the end of the birth month. All examinations taken within this period will be considered to have been taken during the birth month. Reserve Component personnel must take the required examination during the designated fiscal quarter.

(d) Personnel examined in accordance with paragraph 10-23c(3) (student aviators and medical personnel) or 10-26g (FEB, postaccident, illness or injury, preparation for PCS, etc.) within the 6 months preceding the end of their birth month or designated quarter will be considered to have met their periodic examination requirement for the year. In some cases, this may result in a validity period of an examination of up to 18 months, in accordance with table 10-1.

(e) When DA Form 4186 (Medical Recommendation for Flying Duty) is completed after a Type B or interim examination, the last day of the birth month or designated quarter will normally be entered as the date the medical clearance expires. When an examination is given in the early part of the 3-month period preceding the end of the birth month, the DA Form 4186 will expire up to 15 months later. When an examination is given under the provisions of (d) above, the clearance may not expire for 18 months. See table 10-1 and paragraph 10-26j.

Table 10-1. Number of Months for Which a Flying Duty Medical Examination Is Valid (Active Component)

Birth month	Month in which last FDME was given											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jan	12	11	10	9	8	7	18	17	16	15	14	13
Feb	13	12	11	10	9	8	7	18	17	16	15	14
Mar	14	13	12	11	10	9	8	7	18	17	16	15
Apr	15	14	13	12	11	10	9	8	7	18	17	16
May	16	15	14	13	12	11	10	9	8	7	18	17
Jun	17	16	15	14	13	12	11	10	9	8	7	18
Jul	18	17	16	15	14	13	12	11	10	9	8	7
Aug	7	18	17	16	15	14	13	12	11	10	9	8
Sep	8	7	18	17	16	15	14	13	12	11	10	9
Oct	9	8	7	18	17	16	15	14	13	12	11	10
Nov	10	9	8	7	18	17	16	15	14	13	12	11
Dec	11	10	9	8	7	18	17	16	15	14	13	12

Read down left column to examinee's birth month; read across to month of last FDME; intersection number is maximum validity period. When last FDME was within the 3-month period preceding the end of the birth month, validity period will normally not exceed 15 months. When last FDME was for entry into aviation training, for FEB, post-accident, post-hospitalization, pre-appointment (WOC), etc., validity period will range from 7 to 18 months. Validity periods may be extended, in accordance with paragraph 10-26j, by 1 month only for the purpose of completing an examination begun before the end of the birth month.

(3) Student aviators and medical personnel.

★(a) Individuals reporting for initial entry flight training or for the basic course in aviation medicine must have in their possession a copy of the appropriate FDME which has been reviewed and approved by the Cdr, USAAMC. The class of examination required for student aviators will be in accordance with AR 611-85 or 611-110. These examinations are valid for 18 months from the date of examination for this purpose as specified in paragraph 10-17a(2).

(b) Student aviators or aviation medicine students who undergo an initial or repeat Class 1, 1A, or 2 examination or a Warrant Officer Candidate Pre-Appointment examination (done as a flight physical) within the 6 months preceding the end of their birth month or designated quarter will be considered to have met their periodic examination requirement as specified in paragraph 10-23c(2) for the year. The examination may, therefore, be valid for up to 18 months, in accordance with table 10-1.

(4) *Air traffic controllers.* (See para 10-26l below, Air traffic control personnel.)

(5) Class 3 aviation personnel.

(a) Active and Reserve Component members who must meet Class 3 medical fitness standards

for flying duty will undergo an initial Type B examination. The results will be recorded on SF 88 and allied documents. Thereafter, Active Duty personnel will undergo a Type B examination within 3 months before the end of their birth month at ages 20, 25, 30, 35, 40 and annually thereafter. Reserve Component personnel must take the required examination during the designated fiscal quarter.

(b) In those years in which a Type B examination is not required because of age, they will undergo an eye examination; blood pressure, height, weight and hematocrit measurement; audiometric test and electrocardiogram. The results of these tests will be recorded on DA Form 4497-R (fig 10-3).

(c) The provisions of paragraph 10-23c(2)(c), (d) and (e) regarding validity periods apply to Class 3 examinations.

(6) Diving personnel.

(a) Marine (SCUBA) divers must have a Type B examination at ages 19, 21, 23, 25, 27, 29, 31, 33, 35 and annually thereafter. In addition, they will take annually an eye examination, blood pressure, height, weight, and audiometric and electrocardiographic tests. (This annual examination will be recorded on DA Form 4497-R; see fig 10-3.) After

age 35, they will take a Type B examination annually.

(b) Marine divers (MOS 00B, other than SCUBA) must have an annual Type B examination, regardless of age. (This is an Occupational Safety and Health Act requirement.) This examination must be taken within 3 months before the end of the diver's birthday month. The results of the above tests will be reviewed by a flight surgeon or other physician trained in diving or hyperbaric medicine.

(7) *All other personnel on active duty* will undergo a periodic examination within 3 calendar months before the end of the birthday month, at ages 20, 25, 30, 35, 40, 45, 50, 55, 60 and annually thereafter. Periodic examinations of active duty members prior to age 20 are not required. An examination accomplished within the 3 calendar months before the end of the anniversary month will be considered as having been accomplished during the anniversary month.

(8) *The frequency of medical surveillance examinations* varies according to job exposure. Annual or less frequent examinations will be performed during the birthday month. More frequent examinations will be scheduled during the birthday month and at appropriate intervals thereafter.

(9) *All members of the Ready Reserve not on active duty—*

(a) At least once every 4 years during the anniversary month of the examinee's last recorded medical examination. Army commanders, Commander, RCPAC, and the Chief, National Guard Bureau may, at their discretion, direct more frequent medical examinations in individual cases.

(b) Members of the Ready Reserve not on active duty will accomplish a statement of medical fitness annually.

(10) *Under exceptional circumstances*, where conditions of the service preclude the accomplishment of the periodic examination, it may be deferred by direction of the commander having custody of field personnel files until such time as its accomplishment becomes feasible. An appropriate entry explaining the deferment will be made in the health record and on Health Record—Chronological Record of Medical Care (SF 600) when such a situation exists.

(11) *Individuals on duty at stations or locations having inadequate military medical facilities* to accomplish the complete medical examination will be given as much of this examination as local military

medical facilities permit, and will undergo a complete medical examination when official duties take them to a station having adequate facilities.

d. Reporting of medical conditions.

(1) Reporting of the results of periodic medical examinations pertaining to active Army members age 40 and over will be accomplished as prescribed in paragraph 10-31.

(2) Any change in physical profile or limitations found on periodic medical examinations will be reported to the unit commander on DA Form 3349 as prescribed in chapter 9.

(3) Retired personnel will be informed of the results of medical examinations by the examining physician, either verbally or in writing. A copy of the SF 88 may be furnished on request on an individual basis.

10-24. Promotion

a. Officers, warrant officers, and enlisted personnel on active duty, regardless of component, are considered medically qualified for promotion on the basis of the periodic medical examination outlined in paragraph 10-23.

b. Army Reserve officers and warrant officers not on active duty who have been selected for promotion will be considered medically qualified for promotion on the basis of a Type A medical examination accomplished within 1 year of the effective date of promotion. Army National Guard officers and warrant officers will be governed by NGR 40-501.

10-25. Separation

a. There is no statutory requirement for members of the Active Army (including USMA cadets and members of the USAR and ARNG on active duty or active duty for training) to undergo a medical examination incidental to separation from Active Army service. However, except for members retiring after more than 20 years of active service, it is Army policy to accomplish a medical examination if the member requests it.

(1) Active Army members retiring after more than 20 years active duty are required to undergo a medical examination prior to retirement. Results of that examination will be reported as indicated in paragraph 10-31.

(2) The following schedule of separation medical examinations is established:

	Required	Not required	Can be requested by member (in writing)
Retirement after 20 or more years of active duty.	X*		
Retirement from active service for physical disability, permanent or temporary, regardless of length of service.	X*		
Expiration of term of active service (separation or discharge, less than 20 years of service).		X	X
Upon review of health record, evaluating physician or physician assistant (PA)** at servicing MTF determines that, because of medical care received during active service, medical examination will serve best interests of member and Government; e.g., hospitalization for other than diagnostic purposes within 1 year of anticipated separation date.	X*		
Individual is member of the Army National Guard on active duty or active duty for training in excess of 30 days.		X	X
Individual is member of the Army National Guard and has been called into Federal service (10 USC 3502).	X*		
Prisoners of war, including internees and repatriates, undergoing medical care, convalescence or rehabilitation, who are being separated.	X*		
Officers, WOs and enlisted members previously determined eligible for separation or retirement for physical disability but continued on active duty after complete physical disability processing (chap 6, AR 635-40, and predecessor regulations).	X (Plus MEB and PEB)		
Officers, WOs and enlisted members previously processed for physical disability (AR 635-40) and found fit for duty with one or more numerical designators "4" in their physical profile serial.	X*		
All officers, WOs and enlisted members with one or more temporary numerical designators "4" in their physical profile serial.	X*		
Officers and WOs being processed for separation under provisions of specific sections of AR 635-100 that specify medical examination/mental status evaluation.	X*		
Officers and WOs being processed for separation under provisions of AR 635-100, when medical examination/mental status evaluation is not a requirement.		X	X
Enlisted members being processed for separation under provisions of paragraphs 5-3 and 16-4 of chapter 5, chapter 8, and chapter 9, AR 635-200.	X		
Enlisted members being processed for separation under provisions of chapter 13, AR 635-200 (both mental evaluation and medical examination required).	X		
Enlisted members being processed for separation under provisions of section III of chapter 14 and chapter 15, AR 635-200. (Mental status evaluation only is required. Medical examination may be requested by member in writing and, if so requested, should be accomplished expeditiously without regard to time constraints otherwise applicable in this paragraph to voluntary examination.)			X
Enlisted members being processed for separation under provisions of chapter 10, AR 635-200. (If medical examination is requested by member, then mental status evaluation is required.)			X

*See footnotes at end of table.

	Required	Not required	Can be requested by member (in writing)
Discharge in absentia (officers and enlisted members):			
Civil confinement		X	
When BCD or DD is upheld by appellate review and individual is on excess leave		X	
Deserters who do not return to military control		X	
Enlisted members being processed for separation under all other provisions of AR 635-200 not listed above.		X	X

* Examination will be accomplished not earlier than 4 months, nor later than 1 month prior to scheduled date of retirement discharge, relief from active duty or active duty for training.

** PAs may review health records of officers, WOs and enlisted members upon expiration of term of service (separation or discharge) if such authority has been granted by the supervising physician or approved by the MTF commander or unit staff surgeon.

b. When accomplished voluntarily or involuntarily, a medical examination is intended to identify conditions that may require attention. It is not accomplished to determine eligibility for physical disability processing although such could occur as a result of examination findings.

c. Voluntary requests for medical examinations will be submitted to the commander of the servicing medical treatment facility (MTF) not earlier than 4 months nor later than 1 month prior to the anticipated date of separation or retirement. MTF commanders will not request a delay in administrative processing unless physical disability consideration (medical board referral to a physical evaluation board) is deemed appropriate. Commanders and MILPOs of mem-

bers of the ARNG, and all other members who require a medical examination as indicated above, will schedule these examinations with MTF commanders in time to assure completion of the examination not later than 72 hours prior to anticipated separation date. (Close coordination between commanders and MILPOs and MTF commanders is required to assure timely scheduling and completion of the required examination.)

d. Members who have been in medical surveillance programs because of hazardous job exposure will have a clinical evaluation and specific laboratory tests accomplished prior to separation even though a complete medical examination may not be required.

★Section IV. FLYING DUTY MEDICAL EXAMINATIONS (FDME)

(Classes 1, 1A, 2, 2A, and 3)

10-26. Flying Duty

a. *Further FDME guidance.* Other parts of this chapter of special relevance to FDME include—

(1) Paragraph 10-7, Facilities and Examiners (who may administer FDME).

(2) Paragraph 10-16c, Type B medical examination.

(3) Paragraph 10-17a(2) and (3), Validity periods of FDME.

(4) Paragraph 10-21a, Requirement to re-

view the health record in connection with a periodic medical examination.

(5) Paragraph 10-23a(1), Suspension of periodic examination requirements in the event of mobilization.

(6) Paragraph 10-23a(7)(a), Requirement to counsel examinee.

(7) Paragraph 10-23c(2), (3), (4), (5) and (6), Frequency of examination.

(8) Paragraph 10-23c(10), Deferral of periodic examination.

b. General. This section sets forth administrative procedures applicable to flying duty medical examinations (para 4-1). The flying duty medical examination will be used to supervise, maintain, and control the medical fitness of individuals performing such duty. When properly done, this medical examination presents an accurate medical inventory of the individual in the light of the special medical requirements for flying. Abnormal findings on the medical examination constitute a starting point for careful evaluation and treatment. Special emphasis will be given to the eye, ear, cardiovascular and psychiatric examinations, as well as to a detailed elaboration of pertinent data on the Report of Medical History (SF 93). The Standard Form 88 forwarded to the commander having personnel jurisdiction over the examinee will include sufficient information to show what was done concerning treatment and investigation.

c. Definitions.

(1) See AR 600-105 and AR 600-106 for definitions of aerial flight, designation, suspension, rated, aviation service, and related terms.

(2) For the purposes of this regulation, the terms *flying status*, *flight status*, and *flying duty(ies)* are interchangeable and are synonymous with the terms *qualified for aviation service* (rated officers, AR 600-105) and *flight status* (non-rated personnel, AR 600-106). In respect to rated aviators qualified for aviation service, the provisions of this regulation apply equally regardless of whether the individual is assigned to "operational," "non-operational" or "prohibited" status so long as they are otherwise entitled to Aviation Career Incentive Pay.

(3) *Serious illness or serious injury.* This term means any illness or injury that is adjudged by competent medical authority to have significance in relationship to flying safety or efficiency regardless of duration; i.e., cranial fractures, unexplained loss of consciousness, epilepsy, cardiac arrhythmias, encephalitis, renal calculus, rheumatic heart disease, coronary disease, neurological disability, and any disease or condition interfering with normal binocular visual function.

d. Unfitness for aviation service and flying duty.

(1) When a commander believes an individu-

al otherwise qualified for aviation service or on flying status in his command is medically unfit for flying duty, he may suspend the individual concerned and order him to report for the prescribed medical examination for flying (see AR 600-105). The serious effect of suspension of trained flight personnel, including the loss to the Government of their services, demands careful and comprehensive consideration. However, the safety and well-being of the air crew and/or passengers and the need to safeguard valuable aircraft and mission capability are of paramount importance.

(2) Hospitalization, preferably in a military hospital, for a period not to exceed 3 days is authorized for applicants not in the active military service when fitness for flying duty cannot be determined otherwise. However, this period is to be used for diagnostic purposes only and not for the treatment or correction of disqualifying defects.

(3) A finding of fitness or unfitness for flying duty (in any specific capacity) will be made on the basis of the medical history and examination. Elaboration of this recommendation concerning fitness will be made when needed to clarify the individual's status. If an examinee is regarded as medically unfit for flying duty by reason of defects not specifically mentioned in this regulation, he or she nevertheless will be prohibited from the performance of such duty.

(4) An individual on flying status who, at any time, is found to be disqualified for flying duty as a result of a medical examination prescribed in this regulation, will be suspended from flying status or excused from meeting flight requirements. The examining medical officer will officially notify the commander of the examinee concerned in writing and in the most expeditious manner feasible (DA Form 4186 (Medical Recommendation for Flying Duty)). This officer will act on the basis of such notification. An individual will not be restored to flying status until he or she is again able to qualify medically, or has received a waiver for his or her disqualifying defect granted by duly constituted authority. (See para 10-26h; para 2-11, AR 40-3; and AR 600-105.)

e. Medical examination reports.

(1) Complete reports of medical examination

for flying (originals of SF 88, SF 93, SF 520 (Clinical Record—Electrocardiographic Record, and SF 513 (Medical Record—Consultation Sheet), if applicable), accomplished in conjunction with application for flight training pursuant to AR 611-85 and AR 611-110, will be forwarded direct to the commander having personnel jurisdiction over the applicant for medical review as outlined below. In no case will original reports of medical examination be given to the applicant. Entrance into flight training will only be accomplished after determination of medical fitness to undergo such training has been made by the Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333. Reports of medical examination (originals of SF 88, SF 93, SF 520, and SF 513, if applicable) accomplished for continuance on flight duty for Active Army and USAR personnel, to include any supplemental examinations, will be forwarded direct to the Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333 for review. Reports of medical examination (SF 88, SF 93, SF 520, and SF 513, if applicable) accomplished for Army National Guard personnel, to include the periodic examination prescribed in paragraph 10-23, will be processed in accordance with NGR 611-110 and forwarded to the Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333 for final review. They will then be returned to their point of origin, if found qualified. If medically disqualified, they will be sent to the Chief, National Guard Bureau, ATTN: NGB-AVN-OC, Building E6810, Aberdeen Proving Ground, MD 21010-5420 for further administrative action. The State Adjutant General may utilize current reports of medical examination that have previously been reviewed by the Commander, USAAMC for attachment to the Report of Proceedings of the Flying Evaluation Board submitted to the Chief, National Guard Bureau. Direct communication between the State Adjutant General and Commander, USAAMC, for this purpose is authorized.

(2) Clinical medical summaries, including indicated consultations will accompany all unusual flying evaluation board cases forwarded to higher headquarters. Reports of hospital, medical, and physical evaluation boards will be used as a source of valuable medical documentation although their recommendations have no direct bearing on qualification for flying duty.

(3) Concurrent use of the annual medical examination for flying for Federal Aviation Administra-

tion certification is no longer authorized by the FAA. Both sides of the FAA Report of Medical Examination (FAA Form 8500-8) must be completed.

f. Scope. The prescribed Type B medical examination will be conducted in accordance with the scope specified in appendix IX.

g. Type B medical examinations. In addition to the personnel noted in paragraph 4-2, a Type B medical examination, unless otherwise specified below, will be given to—

(1) Military personnel on flying status who have been absent from, or who have been suspended from flying status by reason of a serious illness or injury, or who have been suspended or absent from flying status in excess of 6 months for any other reason.

(2) All designated or rated military personnel ordered to appear before a flying evaluation board (AR 600-105) when a medical question is involved.

(3) All personnel of the operating aircraft crew involved in an aircraft mishap, if it appears that there is any possibility whatsoever that human factors or medical considerations may have been instrumental in causing, or should be investigated as a result of, such accident. A flight surgeon or other qualified medical officer will screen the crewmembers at the earliest practicable time to determine if a Type B medical examination is necessary. All personnel injured as a result of an aircraft mishap will also undergo a Type B medical examination.

h. Waivers.

(1) *General.* A separate request for waiver need not accompany a Report of Medical Examination (SF 88). Recommendation concerning waivers will be made on the Report of Medical Examination by the examiner or reviewing medical official, if space permits. In any case requiring waiver or special consideration, full use will be made of consultations. These will be identified and attached to the Report of Medical Examination on an appropriate clinical form or a plain sheet of lettersize paper. Waiver of minor defects must in no way compromise flying safety or affect the efficient performance of flying duty or the individual's well-being.

(2) *Initial applicants, Classes 1 and 1A.* Waivers will not be requested by the examiners or the examinee. If the examinee has a minor physical defect, a complete medical examination for flying duty will nevertheless be accomplished and details of the defect recorded. The report of examination will be forwarded to Cdr, USAAMC for review. If

the review confirms that the applicant is disqualified, the report will be returned to the examining facility. The report will then be attached to the application for aviation training and forwarded as prescribed in the regulations applicable to the procurement program under which the application is submitted. If one or more major disqualifying defects exist, the examination need not be completed but will nevertheless be forwarded to the Cdr, USAAMC for reference in the event of subsequent reexamination of the applicant. Failure to meet prescribed standards for vision and refractive error will be considered a major disqualifying defect.

(3) *Initial applicants, and continuance, Class 2; and aeromedical PAs, Class 3.* A waiver may be requested by the examinee and/or recommended by the examining physician in item 75, SF 88. In each case of request or recommendation for initial waiver an Aeromedical Summary is required when specified by the Cdr, USAAMC. If a waiver is not recommended by the examining physician, the Cdr, USAAMC is authorized to require an Aeromedical Summary in specific cases when required for full evaluation. *Waivers for minor physical defects*, which will in no way affect the scope and the safe and efficient performance of flying duty, normally will be recommended by the examining physician, in which case the examinee need not make a separate request for waiver. If the waiver for such a condition is not recommended, the examinee may request a waiver from the appropriate authority as identified in paragraph 10-26i(2).

(4) *Nondesignated or nonrated personnel (crew chief, observers, flight medics, door gunners, and other Class 3 personnel).* In nondesignated or nonrated personnel, minor physical defects which will in no way affect the scope and safe, efficient performance of flying duties and which will not be aggravated by aviation duties may be waived by the commander of the unit or station upon favorable recommendation of a flight surgeon. Notification of medical disqualification will be forwarded, in all instances in writing (DA Form 4186), by the flight surgeon concerned to the disqualified individual's commander along with appropriate recommendations for waiver of defects or suspension from flying status in accordance with existing directives. See ARs 600-105 and 600-106.

★*i. Review and waiver action.*

(1) *Review action.* The Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333 will review and make final determination (utilizing

the procedures outlined in para 10-26e(1) for ARNG personnel) concerning medical fitness for—

(a) *Class 1*—Entrance into flight training.

(b) *Class 1A*—Entrance into flight training.

(c) *Class 2*—Individuals in flight training or on flight status as an aviator (military members) or pilot (civilian employees).

(d) *Class 2*—Entrance into training and continuance on flight status as a flight surgeon; entrance into training for aeromedical physician assistant.

(e) *Class 2A*—Entrance into and continuance in training and on duty as an air traffic controller. (See para 10-26l.)

(f) *Class 3*—Continuance on duty as an aeromedical physician assistant. (Class 3, other personnel, in accordance with para 10-26h(4) above.)

(2) *Waiver action.* The only agencies authorized to grant administrative waivers for medically unfitting conditions for aviation personnel are:

(a) Entrance into flight training, *Classes 1 and 1A*, and continuance in aviation service, *Class 2* aviators (except MS): US Army MILPERCEN, HQDA (DAPC-OPA-V), Alexandria, VA 22332-4000 and Chief, National Guard Bureau (NGB-AVN-OC), Building, E6810, Aberdeen Proving Ground, MD 21010-5420. *Class 2, Medical Service Corps* aviators: HQDA (DAPC-OPH-MS), Washington, DC 20324-2000 (through HQDA (DASG-HCO-A)), Washington, DC 20310-2300).

(b) *Class 2, Flight surgeons*; all persons being considered for or while in aeromedical training: HQDA (DAPC-OPH-MC), Washington, DC 20324-2000 (through Commander, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333, and Chief, National Guard Bureau (NGB-ARS), Washington, DC 20310-2500).

(c) *Class 2, DAC pilots*: Local Civilian Personnel Offices. *Class 2, Contract civilian pilots* (Fort Rucker): CG, US Army Aviation Center.

(d) *Class 2A*, Entrance into and continuance in training and on duty as a *military air traffic controller*: HQDA (DAPC-OPE-L-T), Alexandria, VA 22332-0400, and Chief, National Guard Bureau (NGB-AVN-OC), Building E6810, Aberdeen Proving Ground, MD 21010-5420, for conditions disqualifying for military duty even though a valid FAA medical certificate has been issued. (See para 10-26l.)

(e) *Class 2A, Civilian air traffic controllers*: Local Civilian Personnel Offices.

(f) *Class 3, Aeromedical physician assist-*

ants: HQDA (DAPC-OPH-MC), Washington, DC 20324-2000 (through Commander, USAAMC, ATTN: HSYX-AER, Fort Rucker, AL 36362-5333).

(g) *Class 3, Other personnel:* See paragraph 10-26h(4).

(3) *In each of the above*, administrative waivers may be granted only upon written favorable recommendation from the Cdr, USAAMC, and concurrence of intermediate authority, where specified above. This recommendation may include limited flying status (e.g., co-pilot only) and may include requirements for further evaluation. The Cdr, USAAMC, in fulfilling his review and waiver responsibilities, is authorized to issue such policy letters as may be required to provide guidance to examiners in regard to examinations and procedures necessary to determine fitness for flying duty. He may also issue policy letters governing interim disposition of persons with certain remedial and/or minor defects, such as obesity, hypertension, use of systemic medication, and high frequency hearing loss in excess of standards. When annual reevaluation of waivers is required, the examining flight surgeon will insure that all information required by the Cdr, USAAMC, and/or by good medical judgment, is forwarded with the SF 88 and SF 93. To assist in determining medical fitness for flying duty, the Cdr, USAAMC, is authorized to establish an Aeromedical Consultant Advisory Panel (ACAP) consisting of experienced flight surgeons selected by him- or herself and of experienced aviators selected by the CG, USAAVNC, to help determine fitness for flying duty and to help make recommendations for aeromedical disposition to the appropriate waivers or suspension authority.

j. *Use of DA Form 4186 (Medical Recommendation for Flying Duty).* (See also para 10-23c.) (Applies to all aviation personnel, including civilian employee pilots, civilian contractor pilots, and military and civilian air traffic controllers.)

(1) DA Form 4186 is a required official means of certifying that military and civilian personnel are medically fit to perform Army aviation duties. It is required for all personnel who must meet Army Class 1, 1A, 2, 2A, or 3 medical fitness standards (except rated aviators not performing operational flying duty, see below). (FAA medical certificates are also required for certain personnel, see para 10-26k.) The DA Form 4186 is to be completed at the time of: (a) Periodic examination; (b) after an aircraft mishap; (c) reporting to a new duty station

or upon being assigned to operational flying duty; (d) when admitted to a medical treatment facility, sick in quarters or entered into a drug or alcohol rehabilitation program (AR 600-85); (e) when returned to flight status following (d) above; (f) when treated as an outpatient for conditions or with drugs which are disqualifying for aviation duty; (g) when being returned to flight status following restriction imposed under (f) above; and (h) other occasions, as required.

(2) Three copies of the DA Form 4186 will be completed. One copy will be given to the individual; one will be filed in the examinee's health record; and one copy will be sent to the examinee's unit commander who forwards it to the flight records office for inclusion in the flight records, in accordance with AR 95-1. The individual will, upon return to his or her unit following issuance of DA Form 4186, inform his or her commander or supervisor of his or her status and will utilize his or her copy of DA Form 4186 to verify his or her status. Health record copies will be filed as follows:

Most recent DA Form 5186	File on top left
If above grants clearance to fly, then most recent DA Form 4186, if any, which shows a medical restriction from flying	File next under
If a waiver has been granted for any cause of medical unfitness for flying, the most recent DA Form(s) 4186 showing such waiver(s)	File next under
Any additional DA Form(s) 4186 which the flight surgeon determines to be required as a permanent record (Enter "Permanent Record" in "Remarks" section)	File next under
Other DA Form(s) 4186	Destroy

(3) Issuance of this form, following a periodic medical examination (plus an FAA medical certificate when required), will constitute medical clearance for flying duty pending return of final review from the reviewing authority (Cdr, USAAMC, Fort Rucker, AL) if the examinee is found qualified for flying duty in accordance with chapter 4. If a newly discovered medically unfitting condition requiring waiver exists, such waiver must be granted by appropriate authority (para 10-26i(2)) before further flying duties may be performed. However, in the case of minor defects which will in no way affect the safe and efficient performance of flying duty and which will not be aggravated by such duty, the local commander may, upon favorable recommendation of the flight surgeon (DA Form 4186), allow the individual to continue to perform aviation duties, pending completion of the formal waiver process. Consultation on questionable cases will be obtained direct from the Cdr, USAAMC or his or her design-

nated representative. When used for this purpose, the Remarks section of DA Form 4186 will be completed to reflect a limited length of time for which the clearance is being given.

(4) In determining when the next examination is due (item 8), any examination conducted within 3 calendar months before the end of the birth month will be considered to have been accomplished during the birth month. The medical clearance expiration date in item 8 will then normally be the end of the birth month approximately 1 year later. (See also para 10-23c(2)(d) and table 10-1 in regard to clearance up to 18 months.) DA Form 4186 may be signed by a flight surgeon, other physician or physician assistant when used to medically restrict aircrewmembers from flying duty. It may be signed only by a flight surgeon when used to return aircrewmembers to flying duty, except that return to flying duty by health care providers other than flight surgeons may be accomplished with telephonic approval of a flight surgeon if a flight surgeon is not locally available at a given installation. This clearance, to include the name of the consulting flight surgeon, will be recorded in the health record and on DA Form 4186. The term "Flight Surgeon" will be blocked out on DA Form 4186 if the signing official is not a commissioned Medical Corps flight surgeon. If a previously waived condition has changed significantly (i.e., condition worsens), a new waiver must be obtained before further flying duty is authorized. Item 9 of DA Form 4186 will show the date when waiver was first granted for each waived condition as well as date and nature of any significant changes in condition(s) which have been waived. DA Form 4186 may be used by a flight surgeon to extend a currently valid medical examination for a period not to exceed 1 calendar month beyond the end of the birth month or of the designated fiscal quarter for the purpose of completing an examination begun before the end of the birth month or designated fiscal quarter (however, FAA medical certificates cannot be extended).

(5) DA Form 4186 is not required for aviators in nonaviation duty positions but they must undergo periodic Class 2 examinations to determine continued medical fitness for flying duty and must promptly report to the flight surgeon any condition which might be cause for medical disqualification from aviation service. At the time of the periodic examination, and at any other time the aviator's fitness for flying duty is evaluated, entries will be

made on SF 600 (Health Record—Chronological Record of Medical Care) indicating the status or outcome of such evaluation. (See also para 2-11, AR 40-3.)

(6) USAF and USN forms may be substituted when aeromedical support is provided by those Services.

k. FAA medical certificates. (See also para 10-7c.)

(1) In accordance with AR 40-3 and current agreements between the FAA and DOD, Army flight surgeons (Active and Reserve Components) and qualified civilian physicians employed by or under contract with the Army ("qualified" is defined as a physician who is a graduate of a military primary course in aviation or aerospace medicine) are authorized to issue FAA Medical Certificates, Second and Third Class; provided, however, that the facility to which the flight surgeon or civilian physician is assigned or attached must be designated (assigned an FAA number) by the FAA. All FAA-designated facilities are automatically provided copies of all necessary documents, forms, and resupply request forms by the FAA Mike Monroney Aeromedical Center (Code AAC-141), P.O. Box 25082, Oklahoma City, OK 73125 (phone: (Area Code 405) 686-4831). Applications for designation should be forwarded to Commander, USAAMC, ATTN: HSYX-AER, Fort Rucker, AL 36362-5333. Non-flight surgeons are not authorized to issue FAA medical certificates. Physicians who hold civilian AME designations but who are performing duty with the Army will use the FAA number of the facility which is their place of duty.

(2) In no case are military flight surgeons authorized to issue FAA First Class Medical Certificates. However, when specifically authorized by an FAA regional flight surgeon, an Army flight surgeon (or qualified civilian employee physician) may prepare an FAA Medical Certificate, First Class, and forward it to the regional flight surgeon for signature (CONUS only). This will be done only with the prior approval of the regional flight surgeon and this service is available only at the discretion of a regional flight surgeon.

(3) Requirements for FAA medical certificates.

(a) FAA First Class—Applicants for positions as DAC pilots. When these are not already in the possession of the individual at the time of application and are available through (2) above, the applicant must obtain them on the basis of examination by an Army flight surgeon or qualified civilian em-

ployee physician. If not available in this manner, the certificate must be obtained from a civilian aviation medical examiner designated by the FAA to administer FAA First Class examinations (Senior AME).

(b) FAA Second Class—DAC pilots, pilots who are employees of firms under contract with the Army (other than aircraft manufacturers); military and civilian air traffic controllers. These individuals are required to undergo complete annual examination by military flight surgeons or qualified civilian employee physicians (or civilian AMEs, in accordance with para 10-7c) to determine their fitness to fly Army aircraft, in accordance with paragraph 4-3. (The provisions for interim (abbreviated) flying duty medical examinations, described elsewhere in this regulation, do not apply to military or civilian personnel required to possess valid FAA medical certificates.) If the individual should refuse to undergo such examination he or she will be denied medical clearance to fly or control Army aircraft. Following examination by a military flight surgeon or qualified civilian employee physician, however, civilian pilot examinees may elect to obtain their FAA Second Class Certificate from a civilian aviation medical examiner, at their own expense. If a flight surgeon or qualified civilian employee physician is not available within 60-minute travel time, those individuals required to possess FAA Second Class Certificates will normally obtain their FAA certificate from a local civilian aviation medical examiner (funding: see para 10-7g), and fitness for duty will be determined on the basis of this certificate. However, such an individual may be required to undergo further examination by a military or civilian employee physician if any doubt exists as to his or her fitness to fly or control Army aircraft. Questionable cases may be referred to the Cdr, USAAMC for assistance. Failure to undergo examination by a military or civilian employee physician, if so ordered by competent authority, is basis for denying medical clearance to fly or control Army aircraft.

(c) Military and civilian personnel not required to possess FAA medical certificates for their official duties but who request them for personal use may be issued such certificates in accordance with (1) and (2) above, at the discretion of the flight surgeon and workload permitting. FAA medical certificates will not be prepared for individuals who do not request them. In no case will non-flight surgeons issue FAA medical certificates.

(d) Conduct of examination, processing of FAA Form 8500-8, and issuance of FAA Medical Certificates, Second and Third Class, will be in accordance with official policy of the FAA (Guide for AMEs and any other policy issued by FAA). Normally, certificates are issued at the time of examination if the individual is found to be fully qualified. No limitations or restrictions will be imposed except as specifically authorized by FAA. For example, a limitation of "For air traffic control duties only" on a certificate for an ATC may be made by FAA but is not authorized for use by Army flight surgeons.

(e) Use of the SF 88 in lieu of completing the entire FAA Form 8500-8 is not authorized. Both sides of FAA Form 8500-8 must be completed and must be signed by the flight surgeon except in (2) above or when FAA policy indicates otherwise such as when the individual is not qualified; or as otherwise directed by the FAA. (See FAA Guide for Aviation Medical Examiners.)

(f) In no case are flight surgeons or other Army physicians authorized to extend the validity of FAA medical certificates. Personnel required to possess valid FAA certificates while performing their official duties will be given priority, if required, to insure that their certificate does not expire before reexamination.

(g) Army flight surgeons administering examinations for FAA medical certificates will insure that examinations are complete and accurate; that all administrative requirements are met; that processing of all documents is accomplished on a timely basis; and that FAA policy is otherwise followed.

1. *Air traffic control personnel.* Military and civilian ATC personnel will undergo examination annually or as otherwise directed by the FAA. This examination may be performed during the birth month to facilitate scheduling but in no case will extensions be used to align the examination with the birth month. They will also undergo examination when directed by the flight surgeon under such conditions as post-hospitalization, when illness occurs or is suspected, or after an aviation mishap in which air traffic control may have been a factor. Use of DA Form 4186 applies to all ATC personnel (para 10-26k); as does AR 40-8. In addition, all ATC personnel who receive any communication whatsoever from FAA regarding their medical status with FAA will immediately report to the flight surgeon for a determination regarding fitness for ATC duty at Army facilities. (See also paras 4-2, 10-7,

10-17a(3), 10-26i, and 10-26k.)

(1) *Civilian ATC personnel employed by the Army* are medically qualified for employment on the basis of Qualification Standards GS-2152, Civil Service Handbook X-118 (available at local civilian personnel offices). They are also required by Part 65 and Part 67, Federal Aviation Regulations, to possess an FAA Airman Medical Certificate (FAA Form 8500-9) or combination Airman Medical and Student Pilot Certificate (FAA Form 8420-2), Second Class (or higher). Civilian ATC personnel will obtain their FAA Airman Medical Certificate from a military flight surgeon, if available. A photocopy of FAA Form 8500-B will be maintained in the flight surgeon's office. All FAA-designated facilities are automatically provided copies of all necessary documents, forms, and resupply request forms by the FAA Mike Monroney Aeromedical Center (Code AAC-141), P.O. Box 25082, Oklahoma, City, OK 73125 (phone: (Area Code 405) 686-4831). If a military flight surgeon is not available, civilian ATC personnel may obtain their medical certificate from a civilian aviation medical examiner (see para 10-7c).

(2) *Military air traffic control personnel.*

(a) Military ATC personnel must meet FAA standards, must possess an FAA Airman Medical or combination Medical and Student Pilot Certificate, Second Class (or higher), and must also meet Army-unique standards specified in chapter 2 (for enlistment), chapter 3 (for retention), and chapter 4 (for ATC duty). When a military flight surgeon is available (and is performing duty at an FAA-designated military facility) ATCs will be examined by the flight surgeon to determine fitness under FAA and chapters 2, 3, and 4 standards. FAA Form 8500-8 and associated FAA forms will be completed as specified by the FAA. In addition, the following entries will be made in the "NOTES" section on the reverse side of the FAA Form 8500-8:

1. "Examinee also meets the Army-unique standards of AR 40-501" or "Examinee does not meet the Army-unique standards of AR 40-501."

2. The entry specified in quotes in item 72, appendix IX, will also be made in the "NOTES" section and will be signed by the examinee. One photocopy of the FAA Form 8500-8 will then be filed in the health record (AR 40-66); another photocopy will be sent to the Cdr, USAAMC, ATTN: HSXY-AER, Fort Rucker, AL 36362-5333.

(b) If examinee meets FAA and Army unique

criteria, his FAA medical certificate and a local medical clearance for flying (DA Form 4186) will normally be issued at the time of examination. If the flight surgeon issues an FAA medical certificate that is subsequently altered, revoked or changed in any way by FAA, the ATC (who will normally be the recipient of any notice of change made by FAA) will immediately report to the nearest military flight surgeon for further determination of his or her fitness for ATC duty.

(c) If an ATC is examined for an FAA medical certificate but is not issued the certificate by the flight surgeon (due to questionable qualification, outright disqualification or other reason), the flight surgeon follows the instructions in the AME Guide; in most cases, he or she sends the FAA Form 8500-8 and allied forms to FAA where a decision is made and the examinee is subsequently notified. The examinee will then report to the flight surgeon when he or she receives any communication from FAA regarding his or her status such as special issue, waiver, exemption or letter of denial.

(d) When ATC personnel do not meet FAA and/or Army-unique standards, it may be possible to enter or continue ATC duties if all the following conditions are met:

1. The FAA issues an Airman Medical Certificate, with or without a statement of demonstrated ability or other form of "waiver," and

2. The local flight surgeon and the Cdr, USAAMC recommend a waiver, and

3. Waiver is granted by the authority indicated in paragraph 10-26i (MILPERCEN).

To recommend a waiver, the local flight surgeon will prepare and forward an SF 88, SF 93, allied documents, and an Aeromedical Summary to the Cdr, USAAMC, ATTN: HSXY-AER, Ft Rucker, AL 36362-5333.

(e) When ATC personnel obtain their FAA medical certificate from a civilian examiner (see para 10-7c), the examinee will report the outcome of examination to his or her supporting MTF; and a health care provider will ascertain that he or she meets Army unique standards. If FAA and Army standards are met, this will be noted on SF 600 in the health record jacket, and the signed entry required in item 73, appendix IX, will be made on SF 600. A copy of SF 600 will be sent to the Cdr, USAAMC. ATTN: HSXY-AER, Ft Rucker, AL 36362-5333. If the examinee fails to meet FAA or Army standards, local medical officials will consult the Cdr, USAAMC, ATTN: HSXY-AER, Ft.

Rucker, AL 36362-5333 for further guidance.

(3) *Air traffic control trainees (military)*. Individuals reporting for initial ATC training must have in their possession a valid, current FAA Air-

man Medical Certificate, Second Class (FAA Form 8420-2). This may be issued by an appropriate civilian aviation medical examiner or a military flight surgeon in accordance with paragraph 10-7c.

Section V. USMA MEDICAL EXAMINATIONS (RESCINDED)

10-27. US Military Academy (Rescinded)
(Medical examinations for entrance into the United

States Military Academy are governed by AR 40-29.)

Section VI. MOBILIZATION MEDICAL EXAMINATIONS

10-28. Mobilization Medical Examinations
For administrative procedures applicable to mobi-

lization medical examinations (para 6-1), see paragraph 10-22.

Section VII. MISCELLANEOUS MEDICAL EXAMINATIONS

10-29. Miscellaneous Medical Examinations

a. Specialized duties. Medical examination of individuals for initial selection or retention in certain specialized duties requires verification of the absence of disease or anomalies which may affect performance of those duties. As examples, most military occupational specialties in the electronics field require good color vision; marine divers must be free of diseases of the ear; airborne personnel must have full strength and range of motion of extremities. In evaluating such personnel, the examiner will be guided by the requirements for special physical qualifications set forth in pertinent publications, such as chapters 4 and 7 of this regulation, AR 40-5, AR 611-201, TB MED 523, TB MED 279, and TB MED 501.

b. Certain geographical areas.

★(1) When an individual is alerted for movement or is placed on orders for assignment to duty with the system of Army attaches, military missions, military assistance advisory groups, or in isolated areas, the commander of the station to which he or she is assigned will refer the individual and his or her dependents, if any, to the medical facility of the command. The physician of the facility will carefully review the health records and other available medical records of these individuals. Medical fitness standards for certain geographical areas are contained in paragraph 7-13 and will be used in the evaluation and examination processes. In assessing the individual's potentiality for assignment in certain geographical areas, the examiner is urged to make use of other materials such as the *Medical Capabilities Study* (country-by-country), published by the Armed Forces Medical Intelligence Center, Fort Detrick, MD 21701-5000 (AV 343-7214),

which provide valuable information on environmental conditions in foreign countries. Particular attention will be given to ascertaining the presence of any disease or anomaly which may make residence of one or more members of the family inadvisable in the country of assignment. Review of the medical records will be supplemented by personal interviews with the individuals to obtain pertinent information concerning their state of health. The physician will consider such other factors as length of time since the last medical examination, age, and the physical adaptability of the individual to the new area. Additional considerations of importance which bear on the advisability of residence in a given country are the scarcity or nonavailability of certain care and hospital facilities, and dependence on the host government for care. If, after review of records and discussion, it appears that a complete medical examination is indicated, a type A examination will be accomplished. Sponsors and dependents who are particularly anxious for assignments to certain areas are often inclined to minimize their medical deficiencies or hesitate to offer complete information to medical examiners regarding their medical condition or physical defect. The examiner must be especially alert to recognize such situations and fully investigate the clinical aspects of all suspected or questionable areas of medical deficiency. The commander having processing responsibility will insure that this medical action is completed prior to the individual's departure from his or her home station.

(2) The importance of this medical processing cannot be overemphasized. It is imperative that a thorough screening be accomplished as noted in (1) above for the best interests of both the individual

and the Government. Individuals in these assignments function in a critical area. Their duties do not permit unscheduled absences. The peculiarities of the environment in which they and their dependents must live are often deleterious to health and present problems of adaptability for many individuals. In view of the unfavorable environments incident to many of these assignments, it is of prime importance that only those individuals will be qualified whose medical status is such as to provide reasonable assurance of continued effective performance and a minimum likelihood of becoming medical liabilities.

★(3) If as a result of his or her review of available medical records, discussion with the individual and his or her dependents, and findings of the medical examination, if accomplished, the physician finds the individual medically qualified in every respect under paragraph 7-13d and to meet the conditions which will be encountered in the area of contemplated assignment, he or she will complete and sign DA Form 3083-R (Medical Examination for Certain Geographical Areas). This form will be reproduced locally on 8½- by 11-inch paper in accordance with figure 10-2.

(Locate fig 10-2, a fold-in page, at the end of the regular size pages.)

The top margin of the form will be approximately ¾-inch for filing in the health record and outpatient record. A copy of this statement will be filed in the health record or outpatient record (AR 40-66) and a copy forwarded to the commander who referred the individual to the medical facility. If the physician finds a dependent member of the family disqualified for the proposed assignment, he or she will notify the commander of the disqualification. The examiner will not disclose the cause of the disqualification of a dependent to the commander without the consent of the dependent, if an adult, or a par-

ent if the disqualification relates to a minor. If the military member or dependent is considered disqualified temporarily, the commander will be so informed and a re-examination scheduled following resolution of the condition. If the disqualification is permanent or if it is determined that the disqualifying condition will be present for an extended period of time, the physician will refer the military member to a medical board for documentation of the condition and recommendations concerning limitation of activities or areas of assignment. Either DA Form 3947 (Medical Board Proceedings) or DA Form 3349 (Physical Profile) may be used, the selection depending on the eventual use of the report.

(4) Periodic medical examinations may be waived by the commander concerned for those individuals stationed in isolated areas; i.e., Army attachés, military missions and military assistance advisory groups, where medical facilities of the US Armed Forces are not available. Medical examinations so waived will be accomplished at the earliest opportunity when the individuals concerned are assigned or attached to a military installation having a medical facility. Medical examination of such individuals for retirement purposes may not be waived.

c. *Special Forces Initial Qualification, Military Free Fall (HALO) and Special Forces SCUBA Medical Examination Reports.* Entrance into Special Forces Qualification Course, Military Free Fall (HALO), and Special Forces SCUBA training will only be accomplished after determination of medical fitness to undergo such training has been made by the Commander, US Army John F. Kennedy Special Warfare Center, ATTN: Surgeon, Fort Bragg, NC 28307-5000. The SF 88, SF 93 and allied documents will be forwarded direct to the above ATTN line for review. The reviewed medical examination forms and allied documents will be returned direct to the sender to be incorporated in the member's application for training.

Section VIII. MEDICO-DENTAL REGISTRANTS MEDICAL EXAMINATIONS

10-30. Medico-Dental Registrants Medical Examinations

Administrative procedures applicable to medical

and dental registrants under the Universal Military Training and Service Act, as amended, are set forth in AR 601-270.

**★ Section IX. ARMY PHYSICAL FITNESS PROGRAM
FOR ACTIVE MEMBERS AGE 40 AND OVER**

★ 10-31. Medical Evaluation—Army Physical Fitness Program for Active Members Age 40 and Over.

a. Criteria. Routine medical examinations will be utilized as a vehicle for accomplishing the initial cardiovascular screening for personnel 40 years of age and over prior to entry into the Army Physical Fitness Program for Active Members Age 40 and Over. Personnel age 40 and over will not be required to begin a physical training program or be tested prior to cardiovascular screening. This does not exempt personnel from performing normal MOS physical tasks. The procedures to be followed in screening for coronary heart disease will result in calculation of an overall risk index. This risk index will be based on tables derived from the Framingham Study on heart disease which combined input from 7 risk factors to include age, sex, smoking habit, systolic blood pressure, resting ECG for left ventricular hypertrophy, carbohydrate intolerance, and cholesterol.

(1) Additional secondary screening will be required for those who:

(a) Possess a relatively high risk index of 5% or greater.

(b) Have a clinical cardiovascular finding:

1 Have a history suggesting angina pectoris discomfort, dyspnea, syncope, palpitation, hypertension, drug treatment of hypertension, or a family history of a clinical coronary event (angina pectoris, myocardial infarction, sudden death due to natural causes, etc.) in a first order relative (parent or sibling) age 50 or younger.

2 Have a cardiovascular abnormality on physical examination such as persistent hypertension, cardiomegaly, murmur, etc.

(c) Have any abnormality on ECG.

(d) Have a fasting blood sugar of 115 mg % (mg/dl) or over (carbohydrate intolerance).

(2) Personnel who have none of the above factors may be cleared to enter directly into this program. Those who require additional screening may be subsequently cleared and enter the program or may require an individualized program prescribed by the consulting physician.

(3) Personnel 40 years of age or over who are already in training may maintain their current level of exercise until they undergo medical screening and, if cleared, can advance to greater levels of exer-

cise activity. Testing may be accomplished 3 months after cardiovascular screening results in clearance for participation in the Program.

b. Implementation. Implementation of the screening to reach all personnel already age 40 or over required a special schedule for medical examination. All such members received a complete medical examination during the month of birth at age 40, 42, 44, etc. This allowed such members to be screened within a period of approximately 2 years from the date of inception of this Program, 30 June 1981. Personnel are identified for the periodic medical examination and screening for this Program and notified through procedures prescribed in DA Pamphlet 600-8. The cardiovascular screen is administered to all members age 40 or over at the time of each periodic medical examination at 5-year intervals (see para 10-23c) and during the retirement medical examination except when a prior over-40 screen has not been done. The retirement medical examination is mandatory (see para 10-25a). Members currently under age 40 will have a medical examination including cardiovascular screening upon attaining age 40 even if involved in a training program at the time. The cardiovascular screen will be a regular part of every medical examination after age 40.

(1) Commanders at all levels will be responsible for ensuring that all personnel over 40 years of age are screened and subsequently participate in the Physical Fitness Training Program or a modified program as prescribed by consulting physicians.

(2) Commanders at medical centers and MED-DACs are responsible for implementing procedures established in this Program. This requires involvement of the chiefs of ambulatory care and department of medicine in scheduling and processing examinations in a timely manner. Local commanders will be briefed on the capabilities of the medical facility and the timeframe necessary for completion of the screening for all personnel. A continued review will be necessary to ensure accuracy of data collected and full participation by all personnel.

c. Data Processing. A central registry for monitoring, evaluating, and record keeping at the Armed Forces Institute of Pathology (AFIP) will be part of the Program. Close coordination and feedback between personnel records offices and medical examining facilities will be necessary to ensure success of

this critical element of the Program.

(1) The DA Form 4970 (Medical Screening Summary—Over-40 Physical Fitness Program) has

been designed as a single form to accomplish all record keeping and data transmittal in this program. (See fig 10-4 for a sample form.) Data

obtained in the initial screen will be typed on the front of this form and forwarded to the AFIP where a risk index will be calculated to assist the examining facility in decisionmaking. Calculation results and recommendations will be printed in the "For AFIP Use Only" section and returned to the examining facility for processing. The Medical Examining Section will be responsible for processing the examination results and DA Form 4970. A suspense file will be necessary to verify return receipt of all forms which have been forwarded to AFIP. Each time the examination results are forwarded to the AFIP, they will be processed and the form expeditiously returned to the original examining facility. For those personnel who are not cleared, a draft SF 513 (Medical Record—Consultation Sheet) will be prepared and returned with DA Form 4970 to help accomplish a secondary screen. When the secondary screen is completed the results will be entered in a space prepared by the computer in the "For AFIP Use Only" section. The original form will be returned to AFIP. The AFIP will return the form to the examining station for filing as a permanent part of the individual health record when all screening has been completed. A new form should never be initiated at any point in the screening process unless the original has been lost.

(2) Recording the cardiovascular screening and determining clearance for the physical training program will be accomplished on DA Form 4970 and entered on SF 88 (item 73, NOTES) as follows: Favorable or Unfavorable. All required information will be recorded on the original copy of DA Form 4970 and forwarded to the AFIP for recordkeeping, regardless, if local physicians determine eligibility for training and testing. The original copy will be processed by ADP optical readers which will be utilized for timely processing and recording of all data. The process for decisionmaking is outlined within this section. It is sufficiently straightforward to permit local determination with assistance from the reference cited in paragraph *g(3)(b)* below.

(3) The Cardiovascular Screening Program is designed for integration with the periodic medical examination. Mass screening will not be done because the quality of the screening examination will suffer and mass screening will overload the

medical system. Local commanders will have latitude in increasing the number of physicals done in the examining station, where feasible, and thus accelerate the screening. Commanders are reminded that medical examination and followup screening specialty clinics cannot handle excessive screening loads while continuing to support the medical care mission.

d. Screening instructions.

(1) The cardiovascular screen will be based on the 7 risk factors taken from *The Framingham Study*. Virtually all of these risk factors are now being measured in the routine periodic medical examination. The 7 risk factors will be used to calculate a risk factor index as outlined by the American Heart Association Publication 70-003-A, *Coronary Risk Handbook*. A risk factor index of 5% or greater likelihood of developing coronary heart disease in 6 years will require the member to undergo further medical testing within regular medical channels before clearance is given for participation in the Program.

(2) Three additional related factors will be addressed at the time of the initial examination: Positive clinical cardiovascular (CV) history or physical findings, any abnormality of the ECG, and fasting blood sugar of 115 mg % (mg/dl) or greater. Thus a CV risk factor index of 5% or greater, positive CV history or physical finding, any abnormality of the ECG, or a fasting blood sugar of 115 mg % (mg/dl) or greater will require further medical testing before clearance is given for this Program. Personnel with a CV risk index under 5%, negative CV history and physical examination, no abnormality of the ECG and a fasting blood sugar under 115 mg % (mg/dl) will be cleared to enter this Program without further medical attention.

(3) The value obtained for all factors measured will be entered on DA Form 4970 and mailed within 3 days after testing is completed to the Armed Forces Institute of Pathology, ATTN: Department of Cardiovascular Pathology, 14th and Alaska Avenue, NW, Washington, DC 20306. The AFIP will record the data and calculate a supplemental risk index. The risk index and recommendations for subsequent action will be typed in the "For AFIP Use Only" section of the form and returned to the medical ex-

aming facility to assist in decisionmaking. DA Form 4970 with clearance for the Over-40 Fitness Program will be filed in the member's health record. Notification of clearance will then be made by the physical examination section to the individual's personnel records manager, the unit commander and the servicemember.

(4) When an individual is not cleared on an initial screen, further medical or cardiovascular consultation is required. The examining facility will then instruct the servicemember on the requirement for additional evaluation and assist in scheduling the consultant appointment. If the secondary screen results in clearance of the member, the consultation returned to the medical examining facility will contain that recommendation. The medical examining facility will notify the member's personnel officer that clearance has been given for the member to begin training. If consultation finds clearance cannot be given, the consulting physician will include that recommendation on the consultation form and return it to the medical examining facility. The consulting physician will advise an individualized exercise program and other measures based upon his clinical judgment.

(5) When the secondary screen results in clearance for participation in the Program, the medical examining facility will enter the result in the space prepared by AFIP on DA Form 4970 and return the form to AFIP by mail for entry into the computer and subsequent return to the originating facility. The personnel records manager, unit commander, and the individual will be informed of clearance for participation in the program by the physical examination section. When further medical evaluation results in non-clearance, the medical examining facility conducting the examination will again enter the result on DA Form 4970 and return the form to AFIP. After the form is returned by the AFIP, the examining facility will file it in the medical record and accomplish the notification procedure established above.

e. Details for the medical screening examination.

(1) The medical screening examination can be done by the health care professional now performing the periodic medical examinations. All data items, including those now a part of SF

88 (Report of Medical Examination) and SF 93 (Report of Medical History), will be entered on DA Form 4970 (see fig 10-4). This form is designed for ADP optical reader processing and must be completed in accordance with the coding instructions on the form. Information must be complete and accurate. Medical examining facilities will not hold completed forms for bulk mailing since this would defeat the purpose of graduated screening and cause undue delays in implementation of the screening as well as clearance of individuals for entry into the Program.

f. Instructions for completing DA Form 4970.

(1) Enter the date the examination is completed; e.g., 11 Apr 82.

(2) Enter the examining facility MTF code; e.g., 1001.

(3) Patient name; e.g., Doe, John P.

(4) Social security account number without dashes; e.g., 462621593.

(5) The next seven items are the Framingham Factors and are explained as follows:

(a) *Sex*: Enter M for male or F for female.

(b) *Age*: Enter years only as of last birthday; e.g., 40.

(c) *Smoking history*: Enter average number of cigarettes per day; e.g., 40. If the individual does not smoke cigarettes but smokes a pipe, cigars or chews tobacco, enter 0. (For the purpose of local calculation, less than 10 cigarettes per day average will be considered a negative smoking history.)

(d) *Blood Pressure*: Blood pressure should be taken in a quiet place after the member has relaxed and is sitting comfortably with his or her upper arm at heart level. Enter systolic and diastolic pressures in millimeters of mercury; e.g., 120/80.

(e) *Electrocardiogram*: A standard 12 lead scalar resting electrocardiogram will be taken and interpreted according to the routine in each examining facility. Left ventricular hypertrophy will be diagnosed only if definite criteria are present. The criteria of Romhilt and Estes or computerized ECG (CAPOC) criteria for definite LVH will obtain. Borderline and/or sugges-

tive findings will not be counted as abnormalities. Entries will be made as follows: NL = *Normal*; LVH = *Left Ventricular Hypertrophy only*; ABN = *Abnormalities other than LVH*; LVH + ABN = *LVH plus other abnormalities*.

(f) *Serum cholesterol*: The blood will be drawn in the fasting state at least 12 hours after the last meal which should be of low fat content and analyzed by the method standard for that examining facility. The reported value (mg% or mg/dl) will be entered; e.g., 271.

(g) *Fasting blood sugar*: The blood will be drawn in the fasting state at least 12 hours after the last meal and analyzed by the method standard for that examining facility. It is suggested that elevated values be followed up by telephone locally to insure the individual was fasting and by a repeat determination if necessary. The reported value (mg% or mg/dl) will be entered here; e.g., 109.

Note. Accuracy of laboratory determination is critical to the safety of this program. The cholesterol values in the *Coronary Risk Handbook* are based on the Abell-Kendall Method. Individual laboratories must use a factor to correct their cholesterol determinations to the Abell-Kendall values. Guidance on value correction methodology for the purpose of standardization of cholesterol and quality assurance of glucose determination will be obtained from the servicing Regional Medical Center or military reference laboratory (e.g., 10th Med Lab). Blood sugar must be based on true blood glucose level.

(h) *Cardiovascular history and physical findings*:

1. This item will be marked abnormal if any of the following is found on history or physical examination:

- Angina pectoris or suspicious chest discomfort.
- Dyspnea.
- Syncope.
- Precordial palpitation.
- Prior diagnosis of hypertension or treatment of hypertension; history of myocardial infarction.
- History of a clinical coronary event in a first order relative (parent or sibling) under age 50.
- Significant cardiovascular physical finding (e.g., persistent hypertension, pathologic

ic murmur or bruit, cardiomegaly, pathologic heart sound such as third sound, etc.).

• Any other clinical cardiovascular finding which is significant in the judgment of the examiner.

2. Any abnormality of the electrocardiogram: The Framingham Study identified only left ventricular hypertrophy as an ECG risk factor. For the purpose of this screening examination, any definite abnormality of the electrocardiogram will result in non-clearance and require further medical testing. The electrocardiogram results have already been entered above.

3. *Fasting blood sugar*: An elevated fasting blood sugar is a risk factor which results in elevation of the risk index. For the purpose of this medical screening examination, a blood sugar of 115 mg % (mg/dl) or greater will be considered abnormal and result in non-clearance and require further medical testing regardless of the risk index. The blood sugar has already been entered above.

Note. The examining facility must provide the complete return address in the space provided on the reverse side of the form.

g. Directions for further medical testing of those not cleared by the initial screening medical examination:

(1) When non-clearance on the initial screen is entered on DA Form 4970 for any reason, the AFIP will return the form to the originating medical examining facility with a draft consultation sheet (SF 513) accompanying the form to assist the examining facility in the administrative workload. The form will then be forwarded for consultation and further examination by an internal medicine specialist or cardiologist. The member will be notified of time and place for the consultation appointment. Since an exercise tolerance test will customarily be part of this consultation, the member will be directed to report appropriately prepared (e.g., fasting, in comfortable running attire including footgear, and to anticipate a change of clothing before return to duty).

(2) The medical examining facility must provide the consultant with the following:

- (a) Member's individual health record.
- (b) DA Form 4970.

(c) A chest X-ray, if one has been made in conjunction with the current periodic examination.

(d) Consultation sheet, SF 513.

(3) The consultation (secondary screen) should include the following:

(a) An independent history and medical examination recorded on SF 513.

(b) A maximum symptom limited exercise tolerance test after appropriate informed consent. The techniques and criteria contained in the following American Heart Association publications should be helpful: Pub #70-041-A, *The Exercise Standards Book*; Pub #70-008-A, *Exercise Testing and Training of Apparently Healthy Individuals*; Pub #70-008-B, *Exercise Testing and Training of Individuals with Heart Disease or at High Risk for Its Development*; and Pub #70-003-A, *Coronary Risk Handbook*. (These publications have been distributed by The Surgeon General directly to all medical examining facilities.)

(c) Fluoroscopy of the heart for intracardiac calcification, particularly coronary artery calcification if feasible.

(4) If these procedures result in negative or nonremarkable findings, the member should be cleared by the consulting physician. The consultation form will be returned to the originating medical examining facility and filed in the individual's health record. DA Form 4970 will be annotated in the space printed "For AFIP Use Only" and returned to the AFIP where this information will be entered into the computer.

The form will then be returned to be filed in the individual's health record.

(5) When one or more of the above procedures are positive or the consulting physician is of the opinion that the member has medical contraindications to routine entry into this Program, further testing such as stress thalium testing, coronary angiography, etc., may be in order. In this instance, a medical followup program will likely be indicated and a special individualized exercise program based on the safe exercise level achieved on the exercise tolerance test should be prescribed, if medically feasible. The guidance in the American Heart Association publication mentioned earlier will be helpful in this regard. In this instance, the consultation and DA Form 4970 will also be completed and returned to the originating medical examining facility. The DA Form 4970 will be returned to the AFIP where the data will be entered into the computer. DA Form 4970 will then be returned to the examining facility to be filed along with the consultations in the health record. In each case the examining facility will notify the member and the personnel records management officer of final clearance or non-clearance for the Over-40 Physical Fitness Program.

h. Notification of results. The medical examining facility is responsible for notifying the member, the member's command and the personnel records manager of the final status and clearance or non-clearance for the Program.

i. Point of contact. For questions regarding this Program contact HQDA (DASG-PSF), WASH, DC 20310 (AV 224-5475/5476).

THIS FORM WILL BE READ BY A MACHINE - PLEASE READ AND FOLLOW DIRECTIONS BELOW

MEDICAL SCREENING SUMMARY - OVER-40 PHYSICAL FITNESS PROGRAM			
For use of this form, see AR 40-501,102, the proponent agency is the Office of The Surgeon General.			
1. DATE OF EXAM (dd mm yy)	2. MTF CODE	3. PATIENT'S NAME (Last, First, MI)	4. SSN
27 FEB 81	1001	Harrison, Benjamin F.	23456789
5. SEX (M=Male, F=Female)	6. AGE (Current M=Male, F=Female)	7. SMOKING HISTORY (Average num per cigs per day)	8. BLOOD PRESSURE (COCK/COCK mm Hg)
M	42	40	120/100
9. ELECTROCARDIOGRAM (NL=Normal, LVH=Left Ventricular Hypertrophy Only, ABN=Abnormalities other than LVH, LV=Left Ventricle)			10. SERUM CHOLESTEROL (COCK mg %)
LVH + ABN			102
11. FASTING BLOOD SUGAR (mg %)	12. CARDIOVASCULAR HISTORY AND PHYSICAL (NL=Normal, ABN=Abnormal)		
103	ABN		
FOR AFIP USE ONLY			
CODING INSTRUCTIONS			
Typewriter setting: 10 Pitch - double space. Use only "OCR-b" typing element, with high yield carbon ribbon. Type only in spaces provided, using specified codes where indicated. After completion, mail to THE ARMED FORCES INSTITUTE OF PATHOLOGY, ATTN: Dept. of Cardiology, 14th & Alaska Ave., N.W., Washington, DC 20306. Type YOUR return address on reverse side of this form in area indicated.			

DA FORM 4970 4970

Figure 10-4. Sample DA Form 4970, Medical Screening Summary—Over-40 Physical Fitness Program

★CHAPTER II

MEDICAL EXAMINATION TECHNIQUES

Section I. GENERAL

11-1. Scope

This chapter is a guide of medical examination techniques to be used in the medical evaluation of an individual.

11-2. Applicability

These techniques are applicable for type "A" or "B" medical examinations (chap. 10 and app IX).

Section II. HEAD, FACE, NECK, AND SCALP

11-3. Head, Face, Neck, and Scalp

a. Record all swollen glands, deformities, or imperfections of the head and face. In the event of detection of a defect, such as moderate or severe acne, cyst, or scarring, a statement will be made as to whether this defect will interfere with the wearing of military clothing and equipment.

b. The neck will be examined by palpation of the parotid and submaxillary regions; palpation of

the larynx for mobility and position, palpation of the thyroid gland for nodularity and size, and palpation of the supraclavicular areas for fullness and masses. If enlarged lymph nodes are detected they will be described in detail and a clinical opinion of the etiology will be recorded.

c. The scalp will be examined for deformities of the skull in the nature of depression and exostoses, of a degree which would prevent the individual from wearing a military helmet.

Section III. NOSE, SINUSES, MOUTH, AND THROAT

11-4. Nose, Sinuses, Mouth, and Throat

a. If there are no complaints referable to the nose or sinuses, simple anterior rhinoscopy will suffice, provided that in this examination, the nasal mucous membrane, the septum, and the turbinates have a normal appearance. If the individual under consideration has complaints referable to the nose and sinuses, a more detailed examination will be done and recorded. Most commonly, these complaints are external nasal deformity, nasal obstruction, partial or complete on one or both sides; nasal discharge; postnasal discharge, sneezing; nasal bleeding; facial pain; and headaches.

b. Abnormalities in the mucous membrane in the region of the sinus ostia, the presence of pus in specific areas, and the cytologic study of the secretion may provide the examiner valuable information regarding the type and location of the sinus infection. Tenderness over the sinuses should be evaluated carefully. Examination for sinus tenderness should include pressure applied over the anterior walls of the frontal sinuses and the floors of these cavities and also pressure over the cheeks. Determine also, if there is any tenderness to percussion beyond the boundaries (as determined by

X-ray) of the frontal sinuses. Note any sensory changes in the distribution of the supra-orbital or infra-orbital nerves which may indicate the presence of a neoplasm. Note any external swelling of the region of the forehead, orbit, cheek, and alveolar ridge.

c. Many systemic diseases manifest themselves as lesions of the mouth and tongue; namely leukemia, syphilis, agranulocytosis, pemphigus, erythema multiforme, and dermatitis medicamentosa. Thus, an individual with lesions of this type should have the benefit of a complete systemic history and general medical examination, including serological tests for syphilis, urinalysis, and complete blood counts. Note any abnormalities or lesions on lips or buccal mucous membrane, gums, tongue, palate, floor of mouth, and ostia of the salivary ducts. Note the condition of teeth. Particular attention should be paid to any abnormal position, size, or the presence of tremors or paralysis of the tongue and the movement of the soft palate on phonation.

d. Record any abnormal findings of the throat. If tonsils are enucleated, note possible presence, and position of residual or recurrent lymphoid

tissue and the degree of scarring. If tonsils are present, note size, presence of pus in crypts, and any associated cervical lymphadenopathy. Note presence of exudate, ulceration, or evidence of neoplasm. On the posterior pharyngeal wall look for exudate and note its type, whether mucous, frank pus, or crusts. Describe any hypertrophied lymphoid tissue on the posterior pharyngeal wall

or in the lateral angles of the pharynx. Note any swelling or ulceration of the posterior pharyngeal wall. Examine the peritonsillar region and the lateral angle of the pharynx and note if there is evidence of swelling which displaces the tonsil, indicating possible neoplasm or abscess. Mirror examination of the larynx should be performed if the individual complains of hoarseness.

Section IV. EARS AND HEARING

11-5. Ears

a. Careful, specific, and detailed information concerning any complaint referable to the external ear, the middle ear, or the internal ear, such as earache, discharge, hearing impairment, dizziness, or tinnitus, should be recorded.

b. An inspection should include the auricle, the external canal, and the tympanic membrane. Abnormalities (congenital or acquired) in size, shape, or form of the structure must be noted, evaluated, and recorded.

- (1) *Auricle.* Note deformities, lacerations, ulcerations, and skin disease.
- (2) *External canal.* Note any abnormality of the size or shape of the canal and inspect the skin to detect evidence of disease. If there is material in the canal note whether it is normal cerumen, foreign body, or exudate. Purulent exudate in the canal must have its source determined. If this exudate has its origin in the middle ear, record whether it is serous, purulent, sanguinous, or mucoid; whether it is foul smelling; whether it is profuse or scanty; and whether it is pulsating.
- (3) *Drum membrane.* All exudate and debris must be removed from the canal and tympanic membrane before a satisfactory examination can be made. Unless the canal is of abnormal shape, the entire drum membrane should be visualized and the following points noted and recorded.
 - (a) Any abnormality of the landmarks indicating scarring, retraction, bulging, or inflammation.
 - (b) Use a Siegal speculum to determine if the tympanum is air-containing.
 - (c) Note and describe any perforations, giving size and position, indicating

whether they are marginal or central, which quadrant is involved, and whether it is the flaccid or the tense portion of the membrane that is included.

- (4) *The tympanum.* In the case of a perforation of the drum membrane, attempt to determine the state of the middle ear contents, particularly with reference to hyperplastic tympanic mucosa, granulation tissue, cholesteatoma, and bone necrosis. Do the visible pathological changes indicate an acute or a chronic process? This clinical objective examination should permit the examiner to evaluate the infectious process in the middle ear and to make a reasonably accurate statement regarding the chronicity of the infection, the extent and type of involvement of the mastoid; the prognosis regarding the hearing; and the type of treatment (medical or surgical that is required).

11-6. Hearing

a. The external auditory canal should be carefully cleaned of any obstructive material. Some tests are qualitative. These tests have as their goal the classification of auditory responses into general categories rather than the precise measurement of amount of impairment. The examiner should be familiar with the standard tuning fork tests, e.g., the Weber for lateralization of sound; the Schwabach for determining bone conduction; and the Rinne for determining the ratio of bone-to-air condition. These tests provide a check on audiometric results and should be used whenever possible.

b. In cases of vestibular dysfunction the individual usually complains of dizziness. With this

complaint of "dizziness," an attempt should be made to ascertain by careful history taking whether the so-called dizziness is a true vertigo. If the vertigo comes in attacks, record detailed information describing a typical attack, including such things as premonitory signs, associated symptoms, changes in sensorium, direction of falling, duration of attack, and after effects. If the "dizziness" is not characterized by true vertiginous attacks, describe the symptoms exactly and note the time of day the symptoms are worse, any possible association of symptoms with: Fatigue, excitement, the use of drugs, alcohol, or tobacco, dietary indiscretion,

occupation, change of posture, abuse of the eyes, headache, or hearing impairment. These individuals should have a complete general medical examination and should have an ophthalmology and a neurological consultation. The examination of the vestibular apparatus should include—

- (1) Determination of presence of spontaneous nystagmus or past pointing.
- (2) Tests for postural vertigo and positional nystagmus.
- (3) Turning tests.
- (4) Caloric stimulation of the labyrinth.

Section V. DENTAL

11-7. Dental

a. The dental examination will include complete, thorough visual and digital inspection of all soft tissues of the oral region, visual and exploratory inspection of supporting tissues and all surfaces of the remaining natural teeth, and determination of the serviceability of fixed and removable prostheses if present. Diagnostic aids such as roentgenograms,

percussion, thermal, electrical, transillumination, and study casts will be utilized by the examining dentist as required to achieve the purpose of the examination.

b. See AR 40-29 for additional instructions pertaining to US Military Academy applicant examinations.

Section VI. EYES

11-8. Eyes

a. A history of any ocular disease, injury, surgery, medication, loss of vision, diplopia, and the use of glasses or contact lenses will be obtained. An attempt will be made to elicit any pertinent family history, such as a history of glaucoma, retinitis pigmentosa, cataracts, and maternal lues.

★*b.* Individual applicants for entrance in the military service, including those scheduled by the Department of Defense Medical Examination Review Board (DODMERB) for medical examination to enter service academies or ROTC scholarship programs, who wear contact lenses regularly will be advised that they are not required to remove their contact lenses for any period preceding the examination. A written report of refractive error, to include contact lens and spectacle lens prescription data, must be obtained by the examinee from his or her attending ophthalmologist or optometrist. The report, indicating examination was accomplished within 1 year of the military medical examination, will be attached to the SF 88. The strength of contact lenses which the examinee may possess will not be accepted as refractive error, nor will it be entered

as such in item 60, SF 88. Item 73, SF 88 will be annotated to indicate which ocular findings were obtained upon removal of contact lenses.

★*c.* The general examination will include the following points:

(1) Examination of the orbits to determine any bony abnormality of facial asymmetry should be made; the position of the eyes should be determined. Note any exophthalmos, enophthalmos, or manifest deviation of the visual axes.

(2) Observation of gross ocular motility to determine the presence or absence of nystagmus or nystagmoid movements and the concomitant movement of the eyes in the six cardinal directions, right, left, up and to the right, up and to the left, down and to the right, down and to the left.

(3) Presence of epiphora or discharge, position of the puncta, pressure over the lacrimal sac to determine if this produces any discharge from the puncta.

(4) The presence of ptosis, the position of the lashes, inversion or eversion of the lids, the presence of any evidence of inflammation at the lid margins, and the presence of any cysts or tumors.

(5) Ocular tension by digital palpation will be recorded as normal, increased, or low. If other than normal, the tension will be taken with a tonometer and the actual readings recorded. Tonometry will be performed on all examinees after their 40th birthday.

(6) Size, shape, and equality of the pupils, direct consensual, and accommodative pupillary reflexes will be measured. Abnormalities of pupillary reactions will be recorded and investigated.

(7) Palpebral and bullar conjunctiva will be examined by eversion of the upper lid, depression and eversion of the lower lid, and by direct examination with the lids separated manually as widely as possible.

(8) The cornea, anterior chamber, iris, and crystalline lens will be examined by both direct and oblique examination. The cornea will be examined for clarity, discrete opacities, superficial or deep scarring, vascularization, and the integrity of the epithelium. The anterior chamber will be examined for depth, alteration of the normal character of the

aqueous humor, and retained foreign bodies. The irides will be examined for evidence of abnormalities, anterior or posterior synechiae, or other pathologic changes. The crystalline lens will be examined for evidence of clouding opacities.

(9) The media will be examined first with a plano ophthalmoscopic lens at a distance of approximately 18 to 21 inches from the eye. Any opacity appearing in the red reflex on direct examination or on movement of the eye will be localized and described. The fundus will be examined with the strongest plus or weakest minus lens necessary to bring the optic nerve into sharp focus. Particular attention will be paid to the color, surface, and margin of the optic nerve, to the presence of any hemorrhages, exudates, or scars throughout the retina, to any abnormal pigmentation or retinal atrophy, to any elevation of the retina, and to the condition of the retinal vascular bed. The macula will be specially examined for any changes. Any abnormalities observed will be noted.

★ Section VII. CHEST AND LUNGS

11-9. Chest and Lungs

a. All medical examinations accomplished for entrance into Active Duty or Reserve Component service must include a chest X-ray.

b. Medical examinations, when accomplished for separation, discharge or retirement from active duty, must include a chest X-ray.

c. Chest X-ray is not required as a part of periodic or other medical examinations accomplished for Active Duty and Reserve Component members. Such X-rays will only be accomplished when, as a result of the medical history or physical findings, the medical examiner deems that X-ray of the chest is clinically indicated.

(1) Medical examination should be carried out in a thorough systematic fashion as described in any standard textbook on physical diagnosis. Particular care should be taken to detect pectus abnormalities, scoliosis, wheezing, persistent rhonchi, basilar rales, digital clubbing, and cyanosis since any of these findings require additional intensive inquiry into the patient's history if subtle functional abnormalities or mild asthma, bronchitis, or bronchiectasis are to be suspected and evaluated.

(2) There should be no hesitancy in expanding the history if abnormalities are detected during

medical examination or in repeating the medical examination if chest-film abnormalities are detected.

d. The standard PA chest film, if included in any medical examination, is sufficient in most instances, provided it is interpreted carefully. Particular attention must be given to the hila and the areas above the 2d anterior ribs since these areas may be abnormal in the presence of normal spirometry. For flying personnel on whom thoracic surgery is performed, it is essential that both preoperative and postoperative pulmonary function studies be accomplished so that subsequent eligibility for return to flying duties may be more intelligently determined. In addition, flying personnel will be evaluated in a low pressure chamber (to include rapid decompression), with a flight surgeon in attendance, prior to return to flying duties after thoracotomy, and in cases of a history of spontaneous pneumothorax.

e. Of the several conditions that are disqualifying for initial induction, there are three which are most often inadequately evaluated and which result in unnecessary and avoidable expense and time loss following induction. These three are asthma (to include "asthmatic bronchitis"), bronchiectasis, and tuberculosis. Specific comment in amplification of previous paragraphs follows:

(1) *Asthma*. In evaluation of asthma, a careful history is of prime importance since this condition is characteristically intermittent and may be absent at the time of examination. Careful attention to a history of episodic wheezing with or without accompanying respiratory infection is essential. If documentation of asthma after age 12 is obtained from the evaluatee's physician, this should result in rejection even though physical examination is normal.

(2) *Bronchiectasis*. Individuals who report a history of frequent respiratory infections (colds) accompanied by purulent sputum or multiple episodes of pneumonia should be suspected of bronchiectasis. This diagnosis can be further supported or suspected by a finding of posttussive rales at one or both bases posteriorly or by a finding of lacy densities at the lung base on the chest film. If bronchiectasis is considered on the basis of history, medical findings, or chest film abnormalities, confirmatory opinions should be sought from the examinee's personal physician, or the examinee should be referred to the appropriate chest consultant for evaluation and recommendations.

(3) *Tuberculosis*. Active tuberculosis is often asymptomatic and often not accompanied by abnor-

mal physical findings unless the disease is advanced. If only such manifestations as hemoptysis or draining sinuses are looked for, most cases of tuberculosis will be missed. The most sensitive tool for detection of early pulmonary tuberculosis is the chest film. Any infiltrate, cavity, or nodular lesion involving the apical or posterior segments of an upper lobe or superior segment of a lower lobe should be suspected strongly of being tuberculosis. It is thus imperative that all routine chest films be completely scrutinized by an experienced radiologist. Many tuberculous lesions may be partially hidden or obscured by the clavicles. When any suspicion of an apical abnormality exists, an apical-lordotic view must be obtained for clarification. It is neither practical nor possible in most instances to determine whether or not a tuberculous lesion is inactive on the basis of single radiologic examination. For all these reasons, any patient suspected of tuberculosis should be referred to a qualified chest consultant or to an appropriate public health clinic for evaluation. It is not feasible to carry out diagnostic skin tests and sputum studies in a medical examination station.

Section VIII. CARDIOVASCULAR

11-10. Cardiovascular

a. Blood pressure. Blood pressure will be determined with the individual relaxed and in a sitting position with the arm at heart level. Current experience is that "low blood pressure" has been very much overrated in the past and, short of symptomatic postural hypotension, a normal individual may have a systolic blood pressure as low as 85-90 mm. Concern with blood pressure, thus, is to detect significant hypertension. It is mandatory that personnel entrusted to record blood pressure on examinees be familiar with situations that result in spurious elevation. It is only reasonable that a physician repeat the determination in doubtful or abnormal cases and ensure that the proper recording technique was used. Artificially high blood pressure may be observed—

(1) If the compressive cuff is loosely applied.

(2) If the compressive cuff is too small for the arm size. (Cuff width should be approximately one-half arm circumference. In a very large or very heavily muscled individual this may require an "oversize" cuff.)

(3) If the blood pressure is repetitively taken

before complete cuff deflation occurs (trapping of venous blood in the extremity results in a progressive increase in recorded blood pressure).

(4) Prolonged bed rest will not precede the blood pressure recording; however, due regard must be given to physiologic effects such as excitement and recent exercise. Limits of normal for military applicants are defined in appropriate sections of this AR. No examinee will be rejected as the result of a single recording. When found, disqualifying blood pressure will be rechecked for a preponderance based on at least three readings. For the purpose of general military procurement, the preponderant blood pressure will be determined by at least three readings at successive hour intervals during a day period. While emphasizing that a diagnosis of elevated blood pressure not be prematurely made, it seems evident that a single "near normal" level does not negate the significance of many elevated recordings.

(5) Blood pressure determination will be made in accordance with the recommendation of the American Heart Association. The systolic reading will be taken as either the palpatory or auscultatory

reading depending on which is the higher. (In most normal subjects, the auscultatory reading is slightly higher.) (Diastolic pressure will be recorded as the level at which the cardiac tones disappear by auscultation.) In a few normal subjects, particularly in thin individuals and usually because of excessive stethoscope pressure, cardiac tones may be heard to extremely low levels. If the technique can be ascertained to be correct, and there is no underlying valvular defect, a diastolic reading will be taken in these instances at the change in tone. Variations of blood pressures with the position change should be noted if there is a history of syncope or symptoms to suggest postural hypertension. Blood pressure in the legs should be obtained when simultaneous palpation of the pulses in upper and lower extremities reveal a discrepancy in pulse volume or amplitude.

b. Cardiac auscultation. Careful auscultation of the heart is essential so that significant cardiac murmur or abnormal heart sound will not be missed. Experience has shown that significant auscultatory findings may not be appreciated unless both the bell and diaphragm portions of the stethoscope are used in examination. As a minimum, attention should be directed to the second right interspace, second left interspace, lower left sternal border, and cardiac apex. Patients should be examined in the supine position, while lying on the

left side, and in the sitting position leaning slightly forward. In the latter position, auscultation should be performed at the end of a full expiration remaining attuned for a high-pitched diastolic murmur of aortic valve insufficiency.

c. Cardiac murmurs. There are no absolute rules which will allow the physician to easily distinguish significant and innocent heart murmurs. For practical purposes, all systolic murmurs which occupy all or nearly all of systole are due to organic cardiac problems. Similarly, any diastolic murmur should be regarded as evidence of organic heart disease. Experience has taught that the diastolic murmur of aortic valve insufficiency and mitral valve stenosis are those most frequently missed. Innocent murmurs are frequently heard in perfectly normal individuals. In an otherwise normal heart, a slight to moderate ejection type pulmonary systolic murmur is the most common of all murmurs. When accompanied by normal splitting and normal intensity of the components of the second heart sound, such a murmur should be considered innocent. A particularly pernicious trap for the attentive physician is the thin chested young individual in whom such a pulmonary ejection murmur is heard and who, in recumbency, demonstrates persistent splitting of the sec-

ond heart sound. Such a combination suggests the possibility of an atrial septal defect. In such a situation a change from persistent splitting to normal splitting of the second heart sound as the patient sits or stands for practical purposes denies the possibility of atrial communications. Awareness of this minor point will prevent an overdiagnosis of such lesions. Other innocent murmurs which are commonly misinterpreted as evidence of organic heart disease include extra cardiac cardiorespiratory noises, surface contact friction noises in the thin-chested individual, venous hums, and isolated supraclavicular arterial bruits of blood flow in the subclavian arteries. Final interpretation of a murmur must be based on cumulative evidence of history, examination, chest X-rays, and electrocardiogram. In doubtful cases additional opinions should be solicited by appropriate consultation request.

d. Chest X-ray. In most cases a simple posterior anterior chest X-ray will suffice to adequately assess cardiac size and pulmonary vascularity. A misdiagnosis of cardiac enlargement is commonly encountered in the thin-chested individual whose heart, although normal, is limited in anterior-posterior extent and appears broad in lateral dimension. Thus, a final indictment of cardiac enlargement can not be made on the basis of a PA chest X-ray alone. In such cases, and in cases requiring additional consultation for unresolved areas of concern, X-ray views should be obtained in PA, lateral, and both right and left anterior oblique views with barium in the esophagus. Such X-rays allow a more critical evaluation and definitive interpretation. At times it may be necessary to assess cardiac size and the amplitude and vigor of cardiac pulsations by fluoroscopic examination.

Section IX. ELECTROCARDIOGRAM

11-11. Electrocardiogram

a. Electrocardiograms should be accomplished routinely on all the following individuals:

- (1) Those in whom medical history or clinical findings are suggestive of cardiac abnormalities.
- (2) Examinees with a sitting pulse rate of 50 per minute or less.
- (3) Examinees who have reached their 40th birthday or are older.
- (4) Applicants for flying training and all flying personnel.
- (5) Applicants for service academies.
- (6) Personnel who are being examined for retirement.

b. In these individuals the electrocardiogram obtained serve not only to diagnose and screen for possible heart disease but as a base line for future comparison. It is imperative then that a proper

technique of recording the electrocardiogram be followed.

- (1) The routine ECG will consist of 12 leads, namely standard leads 1, 2, 3, aVR, aVL, aVF, and the standard precordial leads V₁ through V₆ recorded at 25 mm per second. All artifacts and machine problems must be eliminated.
- (2) Care must be taken in the proper placement of the precordial electrodes. It is important that the precordial electrodes across the left precordium are not carried along the curve of the rib but maintained in a straight line. Special care must be taken in the placement of the first precordial lead so as to avoid beginning placement in the third interspace rather than the fourth. Electrode paste must not be smeared from one precordial position to another. A standardization mark should be included in each lead recorded.

Section X. SKIN

11-12. Skin

a. Examination. The skin will be examined with the patient completely nude in a well-lighted room, except that female examinees will be prop-

erly draped and the presence of a female attendant is required. Particular attention will be paid to the cutaneous manifestations of systemic disease.

b. Description. All lesions will be fully described. Lesions may be classed as primary or secondary and their size, shape, color, location and distribution will be recorded. Primary lesions are macules, papules, pustules, vesicles, and wheals.

Secondary lesions are scales, crusts, excoriations, fissures, ulcers, erosions, scars, pigmentation, and depigmentation. Tattoos and identifying body marks will be fully described. Pilonidal defects (cyst or tract) will also be fully described.

Section XI. HEIGHT, WEIGHT, AND BUILD

11-13. Height, Weight, and Build

a. A thorough, general inspection of the entire body will be made, noting the proportion and symmetry of the various parts of the body, the chest development, the condition and tone of the muscles and the general nutrition. The build will be recorded as slender, medium, heavy, or obese.

b. Procedures for measuring height and weight:

- (1) *Height.* Recorded in inches and fractions of an inch to the quarter. Shoes will be removed when the height is taken.
- (2) *Weight.* Taken with the clothing removed. The examinee will be weighed on a standard set of scales which is known to be correct. The weight will be recorded to the nearest pound. (Fractions of a pound will not be recorded.)

Section XII. HEMATOLOGY AND SEROLOGY

11-14. Hematology and Serology

a. Hematology.

- (1) Examinees will be questioned carefully to elicit a history of unexplained anemia, splenomegaly, splenectomy, lymphadenopathy or lymph node biopsy, purpura, and abnormal bleeding following trauma or surgery. The skin will be inspected for pallor, icterus, cyanosis, petechiae, purpura, or abdominal, axillary, or cervical scars. The mucous membranes will be inspected for pallor, cyanosis, or icterus. Palpation will be done to detect

the presence of adenopathy or splenomegaly.

- (2) Other hematologic studies will be accomplished as deemed necessary by the examining physician.

b. Serology. A serological test for syphilis, using standard serologic technique, will be performed on all initial examinations and subsequently when clinically indicated, or required by other directives. Positive serologies will be rechecked. Sufficient tests and examinations will be performed to clarify the status of any person who presents a positive blood serology, as outlined in TB Med 230.

Section XIII. TEMPERATURE

11-15. *Temperature.* Abnormal temperatures will be rechecked and adequately explained prior to completion of a medical examination. When the

body temperature is not actually determined, a dash will be entered in item 56, SF 88.

Section XIV. ABDOMEN AND GASTROINTESTINAL SYSTEM

11-16. Abdomen and Gastrointestinal System

a. A careful history is of special importance in evaluating the integrity and function of the digestive system. All symptoms of dysphagia, heartburn, regurgitation, nausea and vomiting, flatulence, abdominal pain, diarrhea, changes in bowel habits, blood in stool, or rectal bleeding must be thoroughly explored.

b. A thorough examination of the abdomen must

be performed with the patient in the supine position as well as an examination in standing position for detection of hernia.

c. The appropriate radiologic and endoscopic examinations should be used when necessary to confirm a diagnosis.

d. When indicated, gastric secretory studies, chemical tests of liver function and stool examinations for blood, eggs, and parasites should be done.

Section XV. ANUS AND RECTUM

11-17. Anus and Rectum

a. When a suspicion of anorectal disease exists, a complete examination of this area should be done, including proctoscopy.

★b. Digital rectal will be accomplished for all examinations for individuals 40 years of age or over.

Section XVI. ENDOCRINE SYSTEM

11-18. Endocrine System

a. Endocrine abnormalities will be evaluated during the general clinical evaluation. The thyroid will be palpated for abnormality and the individual observed for signs of hyper or hypothyroidism. General body habitus will be observed for evidence of en-

docrine dysfunctions.

b. If sugar is found in the urine, repeated urinalysis, a 2-hour postprandial blood sugar and, when indicated, a glucose tolerance test will be accomplished preceded by 3 days of adequate (300 grams daily) carbohydrate intake.

Section XVII. GENITOURINARY SYSTEM

11-19. Genitourinary System

a. *Venereal disease and malformations.* A search will be made for evidence of venereal disease and malformations. The glans penis and corona will be exposed and urethra stripped. The testes and scrotal contents will be palpated, and the inguinal lymph nodes will be examined for abnormalities. When indicated, X-ray, other laboratory examinations, and instrumentation will be conducted.

b. *Female examination.* A pelvic examination will be performed on all female examinees. The presence of a female attendant is required and the examinee will be properly draped. The examination will include bimanual palpation, visual inspection of the cervix and vaginal canal by speculum and, when possible, a Papanicolaou smear. When there is an imperforate hymen or other contraindication to vaginal examination, a rectal examination will be

performed and the method of examination will be noted on SF 88.

c. *Urinalysis.*

(1) Routine urinalysis, to include determination of specific gravity, protein and sugar, and microscopic study will be performed for all examinees. Examining physicians may require examinees to void the urine in their presence. Prior to voiding the examinee must be examined for the presence of venereal disease. When either albumin, casts, white blood cells, or red blood cells are found in the urine, urinalysis should be repeated not less than twice a day on 3 consecutive days. If cellular elements persists in the urine, the two-glass test should be performed to rule out lower urinary tract disease.

(2) If sugar is found in the urine the examinee will be subject to further observation of diabetes. See paragraph 11-18.

Section XVIII. SPINE AND OTHER MUSCULOSKELETAL

11-20. Spine and Other Musculoskeletal

a. *Orthopedic evaluation.* The examinee will perform a series of movements designed to bring into action the various joints and muscles of the body. This purpose is best accomplished by requiring the examinee to follow movements made by the examiner. Gait and posture will be specifically noted.

b. *Examination of range of motion.* Extend the arms and forearms fully to the front and rotate them at the shoulders. Extend the arms at right angles with the body; place the thumbs on the points of the shoulder; raise and lower the arms, bringing

them sharply to the sides at each motion. Extend the arms fully to the front, keeping the palms of the hands together and the thumbs up; carry the arms quickly back as far as possible, keeping the thumbs up, and at the same time raise the body on the toes. (Question the examinee regarding any previous dislocations of the shoulder.) Extend the arms above the head, locking the thumbs, and bend over to touch the ground with the hands, keeping the knees straight. (Question the examinee as to wrist injury for possible scaphoid fracture.) Extend one leg lifting the heel from the floor, and move all the toes freely; move the foot up and down and from side to

side, bending the ankle joint, the knee being kept rigid; bend the knee freely; kick forcibly backward and forward; stand upon the toes of both feet; squat sharply several times; kneel upon both knees at the same time. (If the individual comes down on one knee after the other there is reason to suspect infirmity, such as injury to menisci.) (Question the examinee as to previous injury.) Lack of ability to perform any of these exercises indicates some defect or deformity that should be investigated further.

c. Examination of major joints.

(1) *The shoulder.* With the examinee stripped to the waist, inspect both anteriorly and posteriorly for asymmetry or abnormal configuration or muscle atrophy. From the back, with the examinee standing, observe the scapulo-humeral rhythm as examinee elevates the arms from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is cause for particular careful examination. Palpate the shoulders for tenderness and test range of motion in flexion, extension, abduction and rotation. Compare each shoulder in this respect.

(2) *The back.* With the examinee standing stripped, note the general configuration of the back, the symmetry of the shoulders and hips and any abnormal curvature including scoliosis, abnormal dorsal kyphosis, or excessive lumbar lordosis. Have examinee flex and extend spine and bend to each side, noting ease with which this is done and the presence or absence of pain on motion.

(3) *The knee.* With trousers, shoes, and socks removed observe general muscular development of

legs, particularly the thigh musculature. Have examinee squat, and observe hesitancy, weakness, and presence or absence of pain or crepitus. In the presence of any history of "locking," recurrent effusion, or instability, or when limitation of motion or ligamentous weakness is detected, suitable X-rays should be obtained to include an anteroposterior, lateral, and intercondylar view.

(4) *The elbow.* Have the examinee flex the elbows to a right angle and keeping the elbows against the body note ability to fully supinate and pronate the forearms. If indicated, X-rays should include an anteroposterior and lateral views.

(5) *The wrist and hand.* Observe and compare range of motion of the wrists in flexion, extension, radial deviation, and ulnar deviation. Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor indicating possible underlying organic disease. Have the examinee flex and extend the fingers making sure the distal interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palms.

(6) *The hip.* Have the examinee stand first on one foot and then the other, flexing the non-weight-bearing hip and knee and observing for ability to balance as well as for possible weakness of hip muscles or instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (i.e., the non-weight-bearing) hip.

(7) *The feet.* The feet will be carefully examined for any deformity, the strength of the foot will be ascertained by having the examinee hop on toes.

Section XIX. PSYCHIATRIC

11-21. Psychiatric

a. During the psychiatric interview the examining physician must evaluate each individual sufficiently to eliminate those with symptoms of a degree that would impair their effective performance of duty.

b. The psychiatric interview will be conducted subsequent to the completion of all items on SFs 88 and 93. During the interview, the examinee's behavior will be observed and an estimate made of his or her current mental status. Any evidence of disor-

ganized or unclear thinking, of unusual thought control, of undue suspiciousness or of apathy or "strangeness" will be noted. Any unusual emotional expression such as depression, expansiveness, withdrawal or marked anxiety, which is out of keeping with the content of the interview will be carefully evaluated.

c. The results of the psychiatric examination will be recorded on SF 88, item 42, as normal or abnormal in the space provided. If the individual is disqualified, the defect will also be recorded in item 74, SF 88.

APPENDIX I

DEFINITIONS

For the purpose of this regulation the following definitions apply:

1. Accepted Medical Principles

Fundamental deduction consistent with medical facts and based upon the observation of a large number of cases. To constitute accepted medical principles, the deduction must be based upon the observation of a large number of cases over a significant period of time and be so reasonable and logical as to create a moral certainty that they are correct.

2. Candidate

Any individual under consideration for military status or for a military service program whether voluntary (appointment, enlistment, ROTC,) or involuntary (induction).

★3. Enlistment

The voluntary enrollment for a specific term of service in one of the Armed Forces as contrasted with induction under the Military Selective Service Act.

4. Impairment of Function

Any anatomic or functional loss, lessening, or weakening of the capacity of the body, or any of its parts, to perform that which is considered by accepted medical principles to be the normal activity in the body economy.

5. Latent Impairment

Impairment of function which is not accompanied by signs and/or symptoms but which is of such a nature that there is reasonable and moral certainty, according to accepted medical principles, that signs and/or symptoms will appear within a reasonable period of time or upon change of environment.

6. Manifest Impairment

Impairment of function which is accompanied by signs and/or symptoms.

7. Medical Capability

General ability, fitness, or efficiency (to perform military duty) based on accepted medical principles.

8. Obesity

Excessive accumulation of fat in the body manifested by poor muscle tone, flabbiness and folds, bulk out of proportion to body build, dyspnea and fatigue upon mild exertion, and frequently accompanied by flat feet and weakness of the legs and lower back.

9. Physical Disability

Any manifest or latent impairment of function due to disease or injury, regardless of the degree of impairment, which reduces or precludes an individual's actual or presumed ability to perform military duty. The presence of physical disability does not necessarily require a finding of unfitness for duty. The term "physical disability" includes mental diseases other than such inherent defects as behavior disorders, personality disorders, and primary mental deficiency.

9.1. Physician

A doctor of medicine or doctor of osteopathy legally qualified to prescribe and administer all drugs and to perform all surgical procedures.

10. Questionable Cases

(chap 8)

The case of a physician or dentist who, because of the severity of the physical, medical, mental, or dental condition, may not be able to per-

form a full days work as a military physician or dentist, would require frequent hospitalization, or require assignment limitation to a very restricted geographical area.

11. Retirement

Release from active military service because of age, length of service, disability, or other causes, in accordance with Army regulations and applicable laws with or without entitlement to receive retired pay. For purposes of this regulation this includes both temporary and permanent disability retirement.

12. Sedentary Duties

Tasks to which military personnel are assigned which are primarily sitting in nature, do not involve any strenuous physical efforts, and permit the individual to have relatively regular eating and sleeping habits.

13. Separation (Except for Retirement)

Release from the military service by relief from active duty, transfer to Reserve component, dismissal, resignation, dropped from the rolls of the Army, vacation of commission, removal from office, and discharge with or without disability severance pay.

★APPENDIX II
TABLES OF ACCEPTABLE AUDIOMETRIC HEARING LEVEL

Hearing of all applicants for appointment, enlistment or induction will be tested by audiometers calibrated to the International Standards Organization (ISO 1964) and the American National Standards Institute (ANSI 1969).

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

**Table I. Acceptable Audiometric Hearing Level for Appointment,
Enlistment and Induction
ISO 1964—ANSI 1969**

(Rescinded)

**Table II. Acceptable Audiometric Hearing Level for Army Aviation,
Including Air Traffic Controllers
ISO 1964—ANSI 1969 (Unaided Sensitivity)**

Frequency		500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz
Classes 1 & 1A	Each ear	25dB	25dB	25dB	35dB	45dB	45dB
Class 2 (Aviators)	Better ear	25dB	25dB	25dB	35dB	65dB	75dB
	Poorer ear	25dB	35dB	35dB	45dB	65dB	75dB
Class 2 (Air Traffic Controllers)	Each ear	25dB	25dB	25dB	35dB	65dB	75dB
Class 3	Better ear	25dB	25dB	25dB	35dB	65dB	75dB
	Poorer ear	25dB	35dB	35dB	45dB	65dB	75dB

**Table III. Acceptable Audiometric Hearing Level for Admission to US Military Academy,
Uniformed Services University of Health Sciences, and Army ROTC Scholarship Program
ISO 1964—ANSI 1969 (Unaided Sensitivity)**

(Rescinded)

Table III. Acceptable Audiometric Hearing Level for Admission to the U.S. Military Academy

American Standards Association		International Standards Organization	
Cycles per second (hz)	Each ear	Cycles per second (hz)	Each ear
250	No requirement	250	No requirement
500	15	500	30
1000	15	1000	25
2000	15	2000	25
3000	No requirement	3000	No requirement
4000	40	4000	45
6000	No requirement	6000	No requirement
8000	No requirement	8000	No requirement

Table IV. Conversion Table. (To convert Individual Audiograms from the American Standards Association (ASA) to International Standards Organization (ISO))

AT	ADD
250 cps	15 db
500 cps	15 db
1000 cps	10 db
2000 cps	10 db
3000 cps	10 db
4000 cps	5 db
6000 cps	10 db
8000 cps	10 db

Identify the results of each audiogram as "ASA" or "ISO."

APPENDIX III
TABLES OF WEIGHT

Table 1. Table of Militarily Acceptable Weight (in Pounds) as Related to Age and Height for Males--Initial Procurement

Height (inches)	Minimum (regardless of age)	*MAXIMUM				
		16-20 years	21-30 years	31-35 years	36-40 years	41 years and over
60	100	158	163	162	157	150
61	102	163	168	167	162	155
62	103	168	174	173	168	160
63	104	174	180	178	173	165
64	105	179	185	184	179	171
65	106	185	191	190	184	176
66	107	191	197	196	190	182
67	111	197	203	202	196	187
68	115	203	209	208	202	193
69	119	209	215	214	208	198
70	123	215	222	220	214	204
71	127	221	228	227	220	210
72	131	227	234	233	226	216
73	135	233	241	240	233	222
74	139	240	248	246	239	228
75	143	246	254	253	246	234
76	147	253	261	260	252	241
77	151	260	268	266	259	247
78	153	267	275	273	266	254
*79	159	273	282	281	273	260
*80	166	280	289	288	279	267

* Applies only to personnel enlisted, inducted, or appointed in the Army and enlisted or inducted into the Air Force. Does not apply to Navy or Marine Corps enlistees or inductees.

★Table II. Table of Militarily Acceptable Weight (in Pounds) as Related to Age and Height for Females—Initial Procurement

Height (inches)	Minimum (regardless of age)	Maximum					
		18-20 yrs	21-24 yrs	25-30 yrs	31-35 yrs	36-40 yrs	41 yrs and over
58	90	120	124	126	129	132	135
59	92	122	126	128	131	134	137
60	94	124	128	130	133	136	139
61	96	127	130	132	135	139	141
62	98	128	132	134	137	140	144
63	100	132	134	136	139	143	145
64	102	135	136	139	143	145	149
65	104	138	140	144	148	150	153
66	106	141	145	148	151	154	157
67	109	145	149	152	156	158	162
68	112	150	153	156	160	162	166
69	115	154	157	161	164	167	170
70	118	158	162	165	168	171	174
71	122	162	166	169	173	175	179
72	125	167	171	174	178	181	184
73	128	171	177	179	183	186	190
74	130	175	182	185	188	191	195
75	133	179	187	190	194	196	200
76	136	184	192	196	199	202	205
77	139	188	197	201	204	207	211
78	141	192	203	206	209	213	216
79	144	196	208	211	215	218	220
80	147	201	213	216	219	223	225

★Table III. Table of Acceptable Weights for Army Aviation (Classes 1, 1A, 2, 3) (Rescinded)

See AR 600-9, The Army Weight Control Program.

★Table IV. Table of Acceptable Weight (In Pounds) as Related to Height for Diving Duty. (Rescinded)

See AR 600-9, The Army Weight Control Program.

10 August 1971

C 27, AR 40-501
App IV

★APPENDIX IV
JOINT MOTION MEASUREMENT
(TM 8-640)

Rescinded.