

Section VI. MOBILIZATION MEDICAL EXAMINATIONS

10-28. Mobilization Medical Examinations

For administrative procedures applicable to

mobilization 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, TB MED 251, TB MED 270, TB MED 279 and AR 611-201.

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 attachés, military missions, military assistance advisory groups, or in isolated areas, the commander of the station to which he is assigned will refer the individual and his 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 7-9 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 Health Data Publications of the Walter Reed Army Institute of Research which pro-

vide 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 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

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 in-

discretion, 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 paragraph 10-27g(2) of section V, chapter 10, AR 40-501 for additional instructions pertaining to U.S. 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. External and ophthalmoscopic examinations of the eyes are required on all original examinations, and whenever otherwise indicated. Contact lenses will not be permitted to be worn during any part of the eye examination, including visual acuity testing, and it is essential that such lenses not be worn for the 72 hours preceding examination. The strength of contact lenses which an examinee may possess will not be accepted as his refractive error, nor will it be entered as such in item 60, SF 88. The general examination will include the following specific 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. ~~Tonometry will be performed only by physicians.~~ CA 22

- (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 bulbar 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 or 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. A thorough examination will include a complete history, careful physical examination, and necessary X-ray and laboratory studies. In screening examinations the history and X-ray studies are the most immediately revealing examination techniques.

b. It must be remembered that several disqualifying diseases such as tuberculosis and sarcoidosis may not be detectable by medical examination and the absence of abnormal physical signs does not rule out disqualifying pulmonary disease. Such diseases as well as others (neoplasms and fungus infections) may be detected only by chest roentgenogram.

- (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.

c. The standard PA chest film must be included in any complete medical examination and 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.

d. 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. Ventilatory studies should be done but normal results may be obtained during remissions.
- (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 abnormal 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 in-

dividual 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 insure 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 regards must be given to physiologic effects such as excitement and recent exercise. Limits of normal for various age groups and applicants are defined in appropriate sections of AR 40-501. No examinee will be rejected as the results of a single recording. When found, disqualifying blood pressures will be rechecked for 3 consecutive days in the morning and afternoon of each day and carefully recorded. 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 atuned 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, demonstrate persistent splitting of the sec-

★APPENDIX II

TABLES OF ACCEPTABLE AUDIOMETRIC HEARING LEVEL

Hearing of all applicants for appointment, enlistment, or induction will be tested by audiometers calibrated to either American Standards Association (ASA), or International Standards Organization (ISO) Standards.

All audiometric tracings or audiometric reading recorded on reports of medical examination or other medical records will be clearly identified "Results ASA-1951" or "Results ISO."

Table I. Acceptable Audiometric Hearing Level for Appointment, Enlistment and Induction

American Standards Association (ASA)		International Standards Organization (ISO)	
Cycles per second (hz)	Both ears	Cycles per second (hz)	Both ears
500	Average of the 6 readings (3 per ear) in the three speech frequencies not greater than twenty (20) decibels with no level greater than twenty-five (25) decibels.	500	Average of the 6 readings (3 per ear) in the speech frequencies not greater than thirty (30) decibels with no level greater than thirty-five (35).
1000		1000	
2000		2000	
4000	50 (each ear)	4000	55 (each ear)

OR

If the average of the three speech frequencies is greater than 20 decibels (ASA) or 30 decibels ISO reevaluate the better ear only in accordance with the following table of acceptability.

	ASA	ISO
500 (hz)	15 decibels	30 decibels
1000 (hz)	15 decibels	25 decibels
2000 (hz)	15 decibels	25 decibels
4000 (hz)	30 decibels	35 decibels
The poorer ear may be totally deaf.		

APPENDIX II—Continued

Table II. Acceptable Audiometric Hearing Level for Army Aviation

		American Standards Association (ASA)				International Standards Organization (ISO)			
		500 (hz)	1000 (hz)	2000 (hz)	4000 (hz)	500 (hz)	1000 (hz)	2000 (hz)	4000 (hz)
Class 1 & 1A	Each ear	15 db	15 db	15 db	40 db	30 db	25 db	25 db	45 db
Class 2	Better ear	20	20	20	-----	35	30	30	-----
	Poorer ear	20	40	40	-----	35	50	50	-----
Class 3	Better ear	20	20	40	-----	35	30	50	-----
	Poorer ear	-----	-----	-----	-----	-----	-----	-----	-----

APPENDIX III

TABLES OF WEIGHT

Table I. 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	21-24 years	25-30 years	31-35 years	36-40 years	41 years and over
60	100	163	173	173	173	168	164
61	102	171	176	175	175	171	166
62	103	174	178	178	177	173	169
63	104	178	182	181	180	176	171
64	105	183	184	185	185	180	175
65	106	187	190	191	190	185	180
66	107	191	196	197	196	190	185
67	111	196	201	202	201	195	190
68	115	202	207	208	207	201	195
69	119	208	213	214	212	206	200
70	123	214	219	219	218	211	205
71	127	219	224	225	223	216	210
72	131	225	231	232	230	224	216
73	135	231	239	238	237	230	223
74	139	237	246	246	243	236	229
75	143	243	253	253	251	243	235
76	147	248	260	260	257	250	241
77	151	254	267	267	264	256	248
78	153	260	275	273	271	263	254
★*79	159	266	281	279	277	269	260
★*80	166	273	288	286	284	276	267

★*Applies only to personnel enlisted, inducted or appointed in Army and enlisted or inducted into 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 years	21-24 years	25-30 years	31-35 years	36-40 years	41 years and over
58 -----	90	121	123	126	124	135	135
59 -----	92	123	125	129	126	139	138
60 -----	94	125	127	132	128	142	141
61 -----	96	127	129	135	131	145	141
62 -----	98	129	132	139	132	148	147
63 -----	100	135	136	141	136	151	150
64 -----	102	136	140	144	140	155	154
65 -----	104	140	144	148	145	159	158
66 -----	106	144	149	151	150	164	163
67 -----	109	147	151	156	154	168	167
68 -----	112	152	158	159	159	172	171
69 -----	115	158	160	164	162	176	175
70 -----	118	162	166	168	167	181	180
71 -----	122	168	171	171	171	185	184
72 -----	125	171	175	176	175	189	188

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Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
24	✓	✓	Record abnormal findings. If ptosis of lids is detected, a statement will be made as to the cause and the interference with vision. When pterygium is found, the following should be noted: 1. Encroachment on the cornea, in millimeters, 2. Progression, and 3. Vascularity.	Ptosis, bilateral, congenital. Does not interfere with vision. Pterygium, left eye. Does not encroach on cornea, nonprogressive, avascular.
25	✓	✓	Whenever opacities of the lens are detected, a statement is required regarding size, progression since last examination, and interference with vision.	Redistribution of pigment, macular, rt. eye, possibly due to solar burn. No loss of visual function. No evidence of active organic disease.
26	✓	✓	Record all abnormal findings.	
27	✓	✓	Record all abnormal findings.	
28	✓	✓	If rales are detected, state cause. The examinee will be evaluated on the basis of the cause of the pulmonary rales and not simply on the presence of rales.	Sibilant and sonorous rales throughout chest. Prolonged expiration. See item 73 for cause.
29	✓	✓	Abnormal heard findings are to be described completely. Whenever a cardiac murmur is heard, the time in the cardiac cycle, the intensity, the location, transmission, effect of respiration or change in the position and a statement as to whether the murmur is organic or functional will be included. When murmurs are described by grade, indicate basis of grade (IV or VI).	Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted. Disappears on exercise and deep inspirations (physiological murmur).
30	✓	✓	Adequately describe any abnormalities. When varicose veins are present, a statement will include location, severity, and evidence of venous insufficiency.	Varicose veins, mild, posterior superficial veins of legs. No evidence of venous insufficiency.
31	✓	✓	Include hernia. Note any abdominal scars and describe the length in inches, location and direction. If a dilated inguinal ring is found, a statement will be included in item 31 as to the presence or absence of a hernia.	2½ in. linear diagonal scar, right lower quadrant.
32	✓	✓	Digital rectal required for all periodic examinations of active duty personnel regardless of age of examinee, and for all other personnel age 40 and over. A definite statement will be made indicating the examination was performed. Note surgical scars and hemorrhoids in regard to size, number, severity, and location. Check fistula, cysts, and other abnormalities.	One small external hemorrhoid, mild. Digital rectal normal.
33	✓	✓	Record all abnormal findings.	
34	✓	✓	Whenever a varicocele or hydrocele is detected, a statement will be included indicating the size and the presence of pain. If an undescended testicle is detected a statement will be included regarding the location of the testicle, particularly in relation to the inguinal canal.	Varicocele, left, small.

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Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
35	✓	✓	Record any abnormality or limitation of motion. If applicant has a history of previous injuries or fracture of the upper extremity, as for example, a history of a broken arm with no significant finding at time of examination, indicate that no deformity exists and function is normal. A positive statement is to be made even though the "normal" column is checked. If a history of dislocation is obtained, a statement that function is normal at this examination, if appropriate, is desired.	No weakness, deformity or limitation of motion, left arm.
36	✓	✓	Record any abnormality. When flat feet are detected, a statement will be made as to the stability of the foot, presence of symptoms, presence of eversion, bulging of the inner border and rotation of the astragalus. Pes planus will not be expressed in degrees, but should be recorded as mild, moderate or severe.	Flat feet, moderate. Foot stable, asymptomatic, no eversion or bulging, no rotation.
37	✓	✓	Record as for item 35.	
38	✓	✓	Include pelvis, sacroiliac, and lumbrosacral joints. Check history. If scoliosis is detected, the amount and location of deviation, in inches from the midline, will be stated.	Scoliosis, right, ½ inch from midline at level of T-8.
39	✓	✓	Only scars or marks of purely identifying significance or which interfere with function are recorded here. Tattoos which are obscene or so extensive as to be unsightly will be described fully.	1 inch vertical linear scar, dorsum left forearm. 3 inch heart-shaped tattoo, nonobscene, lateral aspect middle 1/3 left arm.
40	✓	✓	Describe pilonidal cyst or sinus. If skin disease is present, its chronicity and response to treatment should be recorded. State also whether the skin disease will interfere with the wearing of military clothing or equipment.	Small, discrete, angular, flat papules of flexor surface of forearms with scant scale; violaceous in color; umbilicated appearance and tendency to linear grouping. Similar lesion on glans penis.
41	✓	✓	Record complete description of any abnormality.	
42	✓	✓	Record all abnormalities. This is not to be confused with ARMA.	
43	✓	✓	Check vaginal or rectal. Record any abnormal findings.	
44			Record the type of dental examination (para 127, AR 40-3). In the case of Type A medical examinations, except for separation purposes, the entry will be recorded as acceptable or nonacceptable in lieu of completing a dental chart and dental classification. A Type 3 dental examination with completion of a dental chart and classification is required in separation medical examinations. A Type 2 dental examination is required in Type B medical examinations; a dental chart and classification will be completed.	Type 3, Acceptable. Type 2, Class 2.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
66	—	✓	Identify test used and results. If a visual field defect is found or suspected in the confrontation test, a more exact perimetric is made using the perimeter and tangent screen. Findings are recorded on visual chart and described in item 73. Copy of chart must accompany original SF 88.	Confrontation test: Normal, full.
67	—	(*)	*Only if indicated by history, record results. If not indicated enter NIBH.	NIBH.
68	—	✓	Record test results and describe all abnormalities.	Normal.
69	(*)	(*)	*Only if indicated. Tonometry on all personnel age 40 and over. Record results numerically in millimeters of mercury of intraocular pressure. Describe any abnormalities; continue in item 73 if necessary.	Normal. O.D. 18.9. O.S. 17.3.
70	—	—	Not required. Enter dash in each space.	
71	✓	✓	Test and record results at 500, 1000, 2000, and 4000 cycles and except for service academies for which 3000 and 6000 will also be tested and results recorded.	

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
72	(*)	✓	<p>*Only if indicated.</p> <p>Adaptability Rating for Military Aeronautics (ARMA) required for Army Aviation. Enter as "ARMA satisfactory" or "ARMA unsatisfactory." Unsatisfactory ARMA required a summary of defects responsible for failure in item 73. ARMA, Reading Aloud</p> <p>★Test (RAT) and DA Form 3742 required for service academies and preparatory schools. Results of other psychological testing, when accomplished, will be attached to SF 88.</p>	<p>ARMA sat.</p> <p>ARMA unsat.—</p> <p>See item 73.</p>
73	✓	✓	<p>If SF 93 is not used, the examinee will enter a brief statement about the state of his health since his last examination. Examiner will enter notes on examination as necessary. Significant medical events in the individual's life such as major illnesses or injuries, and any illness or injury since the last in-service medical examination will also be entered. Such information will be developed by reviewing health record entries and questioning the examinee. Complications or sequelae, or absence thereof will be noted where appropriate. Do not use "NS." Comments from other items may also be continued in this space. If additional space is needed, use SF 507. History and related comments recorded on SF 93, when this form is used, will not be transferred or commented on except as necessary in connection with the examination.</p>	<p>No significant or interval history.</p> <p>Traumatic cataract, left eye, removed 29 July 1964, no comp., see item 59-60 for vision correction.</p> <p>Item 72 cont: History of multiple idiopathic syncopal attacks.</p>
74	✓	✓	<p>Summarize medical and dental defects considered to be significant. Those defects considered serious enough to require disqualification or future consideration, such as waiver or more complete survey, must be recorded. Also record any defect which may be of future significance, such as nonstatic defects which may become worse. Enter item number followed by short, concise diagnosis; do not repeat full description of defect which has already been described under appropriate item. Do not summarize minor, nonsignificant findings.</p>	
75	✓	✓	<p>Notation will be made of any further specialized examinations or tests that are indicated. Item 75 will also include the statement "gas mask spectacles required (AR 40-3)" whenever indicated under the criteria set forth in AR 40-3.</p>	
76	✓	✓	<p>The physical profile as prescribed in chapter 9 will be recorded.</p>	1 1 1 1 2 1
77	✓	(*)	<p>*Except as noted below, check box A or B, as appropriate, and enter purpose of the examination as stated in item 5. Though not required, this item may be completed as a recommendation of the examining physician in the case of applicants or nominees for the USMA or the USNA. No entry will be made for USAFA applicants or nominees.</p>	
78	✓	✓	<p>List all disqualifying defects by item number. This listing is required even though the defects are stated in item 74. If qualified enter a dash.</p>	

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C. 552a)

TITLE OF FORM Periodic Medical Examination (Statement of Exemption)	PRESCRIBING DIRECTIVE AR 40-501
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1. AUTHORITY 5 US Code 301 - Departmental Regulations 42 US Code - Social Security
10 US Code 1071 - Medical and Dental Care, Purposes
44 US Code 3101 - Records Management by Agency Heads; General Duties

2. PRINCIPAL PURPOSE(S)

To advise personnel officers/commanders that the individual has undergone a medical examination and rescheduling a mandatory periodic examination (based upon the age of the member) is not required.

3. ROUTINE USES

Each active Army member must undergo medical examinations periodically (based upon the age of the member). Scheduling is done by unit personnel officers. If the individual has undergone an examination within one year of the proposed mandatory examination, another examination will not be required.

4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION

If the individual does not submit the form when it is indicated he/she will be required to undergo the prescribed medical examination.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

(5 U.S.C. 552a)

TITLE OF FORM Statement of Medical Condition (When Examined More Than 3 Days Prior to Separation)	PRESCRIBING DIRECTIVE AR 40-501
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1. AUTHORITY 5 US Code 301 - Departmental Regulations 42 US Code - Social Security
10 US Code 1071 - Medical and Dental Care, Purposes
44 US Code 3101 - Records Management by Agency Heads; General Duties

2. PRINCIPAL PURPOSE(S)

To preclude the necessity of repeating medical examinations.

3. ROUTINE USES

Army members who have undergone medical examination more than 72 hours prior to separation from active Army service. The member indicates whether in his/her opinion there has been a change in his/her state of health since the complete medical examination was accomplished. If the individual indicates a change has occurred a complete reexamination must be accomplished.

4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION

If the information is not provided both the well-being of the individual and the interests of the government will be adversely effected.

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C. 552a)

TITLE OF FORM

Medical Recommendation for Flying Duty

PRESCRIBING DIRECTIVE

AR 40-501

1. AUTHORITY 5 US Code 301 - Departmental Regulations 42 US Code (AR 604-14) Social Security
10 US Code 1071 - Medical and Dental Care, Purposes
44 US Code 3101 - Records Management by Agency Heads; General Duties

2. PRINCIPAL PURPOSE(S)

Purpose is to grant medical clearance when reporting to a new duty station, after a medical examination, after an aircraft accident or at any other time deemed appropriate by the physician providing medical care to the aviator concerned. This form also provides a means for medically recommending actions that would either qualify or disqualify the individual for a given period of time depending upon existing conditions with a place for recording the medical restriction information.

3. ROUTINE USES

- a. Used to provide a uniform method of reporting aeromedical data. Until introduction of this form, locally produced forms were used and desired data was often omitted or irretrievable if recorded.
- b. Accurate morbidity data regarding Army aviators can be accumulated to allow better management of the aviator population.
- c. Used to inform the unit commander of medical restrictions that affect an aviator under his command.
- d. Provides a record of profile of the individual concerned.
- e. Provides a record of waiver, if any, with any restrictions imposed by the waiver.
- f. Information obtained will be analyzed to provide a basis for changes in physical standards, frequency of periodic examination and scope of physical examinations.

4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION

Mandatory disclosure is necessary if all the various uses of this form are to be realized. Uniform treatment of problem aeromedical cases can be accomplished only by proper accurate utilization of this form.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

(5 U.S.C. 552a)

TITLE OF FORM		PRESCRIBING DIRECTIVE
Medical Condition - Physical Profile Record		AR 40-501
1. AUTHORITY 5 US Code 301 - Departmental Regulations 42 USC Code (AR 604-14) Social Security		
10 US Code 1071 - Medical and Dental Care, Purposes		
44 US Code 3101 - Records Management by Agency Heads; General Duties		
2. PRINCIPAL PURPOSE(S)		
To advise the military personnel officer/commander of changes in physical condition of Army members.		
3. ROUTINE USES		
At any time an Army member suffers disease or injury that temporarily or permanently reduces the functional capacity of one or more body systems. The form is used by profiling officers (1 physician) and by medical boards (3 physicians and the MTF commander) to advise personnel officers/commander of changes in an Army member's physical condition and the assignment limitations that are medically recommended		
4. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION		
If the information is not provided personnel officers/commanders will not be aware of the state of health of all members of the command.		

DATA REQUIRED BY THE PRIVACY ACT OF 1974

(5 U.S.C. 552a)

TITLE OF FORM

Medical Recommendation for Flying Duty

PRESCRIBING DIRECTIVE

AR 40-501

1. AUTHORITY 5 US Code 301 - Departmental Regulations 42 US Code (AR 604-14) Social Security
 18 US Code 1071 - Medical and Dental Care, Purposes
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3. ROUTINE USES

- a. Used to provide a uniform method of reporting aeromedical data. Until introduction of this form, locally produced forms were used and desired data was often omitted or irretrievable if recorded.
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CHAPTER 2

MEDICAL FITNESS STANDARDS FOR APPOINTMENT, ENLISTMENT, AND INDUCTION

(Short Title: PROCUREMENT MEDICAL FITNESS STANDARDS)

Section I. GENERAL

2-1. Scope

This chapter sets forth the medical conditions and physical defects which are causes for rejection for military service in peacetime. For medical fitness standards during mobilization, see chapter 6.

2-2. Applicability

These standards apply to—

a. Male and female applicants for appointment as commissioned or warrant officers in the U.S. Army, regardless of component. (Special categories of personnel such as physicians, dentists, and other specialists liable for military service under the Military Selective Service Act of 1967 will be procured under standards prescribed by the Secretary of the Army in appropriate personnel procurement program directives.)

b. Male and female applicants for enlistment in the U.S. Army, regardless of component. These standards are applicable until enlistees have completed 4 months of active duty or active duty for training under the Reserve Enlistment Program 1963 for medical conditions or physical defects existing prior to original enlistment or induction. (See also AR 635-40, AR 635-200, AR 135-178, and NGR 25-3 for administrative procedure for separation for medically unfitting conditions that existed prior to service.)

c. Male and female applicants for reenlistment in the U.S. Army (regardless of component) after a period of more than 90 days has elapsed since discharge.

d. Applicants for the Army ROTC Scholarship Program, the Advanced Course Army ROTC and other personnel procurement programs, other than induction for which these standards are prescribed.

★*e.* Retention of cadets of the United States Military Academy, except for such conditions that have been diagnosed since entrance into the Academy. With respect to such conditions upon recommendation of The Surgeon General, the medical fitness standards of chapter 3 are applicable to retention in the Academy and subsequent appointment in the Regular Army or entry on active duty in enlisted status.

f. Registrants who undergo preinduction or induction medical examination pursuant to the Military Selective Service Act of 1967 except medical and dental and allied medical specialists registrants who are to be evaluated under chapter 8.

g. "Draft-eligible" male applicants for enlistment in the U.S. Air Force.

h. Male applicants for enlistment or reenlistment in the U.S. Navy or Naval Reserve.

i. "Chargeable accessions" for enlistment in the U.S. Marine Corps or Marine Corps Reserve.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

2-3. Abdominal Organs and Gastrointestinal System

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

a. *Cholecystectomy*, sequelae of, such as post-operative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, or incisional hernia, or postcholecystectomy syndrome when symptoms are so severe as to interfere with normal performance of duty.

b. *Cholecystitis*, acute or chronic, with or without cholelithiasis, if diagnosis is confirmed by usual laboratory procedures or authentic medical records.

c. *Cirrhosis* regardless of the absence of manifestations such as jaundice, ascites or known esophageal varices, abnormal liver function tests with or without history of chronic alcoholism.

d. *Fistula* in ano.

e. *Gastritis*, chronic hypertrophic, severe.

f. *Hemorrhoids*.

(1) External hemorrhoids producing marked symptoms.

(2) Internal hemorrhoids, if large or accompanied with hemorrhage or protruding intermittently or constantly.

g. *Hepatitis* within the preceding 6 months, or persistence of symptoms after a reasonable period of time with objective evidence of impairment of liver function.

h. *Hernia*:

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

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

i. *Intestinal obstruction* or authenticated history of more than one episode, if either occurred during the preceding 5 years or if resulting condition remains which produces significant symptoms or requires treatment.

j. *Megacolon* of more than minimal degree,

diverticulitis, *regional enteritis* and *ulcerative colitis*. Irritable colon of more than moderate degree.

k. *Pancreas*, acute or chronic disease of, if proven by laboratory tests, or authenticated medical records.

l. *Rectum*, stricture or prolapse of.

m. *Resection*, gastric or of bowel; or *gastroenterostomy*; however minimal intestinal resection in infancy or childhood (for example: for intussusception or pyloric stenosis) is acceptable if the individual has been asymptomatic since the resection and if surgical consultation (to include upper and lower gastrointestinal series) gives complete clearance.

n. *Scars*.

(1) Scars, abdominal, regardless of cause, which show hernial bulging or which interfere with movements.

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

o. *Sinuses* of the abdominal wall.

p. *Splenectomy*, except when accomplished for the following:

(1) Trauma.

(2) Causes unrelated to diseases of the spleen.

(3) Hereditary spherocytosis.

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

q. *Tumors*. See paragraphs 2-40 and 2-41.

r. *Ulcer*:

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

(2) Authentic history of surgical operation(s) for gastric or duodenal ulcer.

s. *Other* congenital or acquired abnormalities and defects which preclude satisfactory performance of military duty or which 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 less anemia—until both condition and basic cause are corrected.

(2) Deficiency anemia, not controlled by medication.

(3) Abnormal destruction of RBC's: Hemolytic anemia.

(4) Faulty RBC construction: Hereditary hemolytic anemia, thalassemia, and sickle cell anemia.

(5) Myelophthisic anemia: Myelomatosis, leukemia, Hodgkin's disease.

(6) Primary refractory anemia: Aplastic anemia, DiGuglielmo's syndrome.

b. Hemorrhagic states:

(1) Due to changes in coagulation system (hemophilia, etc.).

- (2) Due to platelet deficiency.
- (3) Due to vascular instability.
- c. *Leukopenia*, chronic or recurrent, associated with increased susceptibility to infection.
- d. *Myeloproliferative disease (other than leukemia)*:
 - (1) Myelofibrosis.

- (2) Megakaryocytic myelosis.
- (3) Polycythemia vera.
- e. *Splenomegaly* until the cause is remedied.
- f. *Thromboembolic disease* except for acute, nonrecurrent conditions.

★*a. Limitation of motion.* An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below (TM 8-640).

(1) *Hip.*

- (a) Flexion to 90°.
- (b) Extension to 10° (beyond 0).

(2) *Knee.*

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

(3) *Ankle.*

- (a) Dorsiflexion to 10°.
- (b) Plantar flexion to 10°.

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

b. Foot and ankle.

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

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

(3) Claw toes precluding the wearing of combat service boots.

(4) Clubfoot.

(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, spastic.

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

(8) Hammer toe which interferes with the wearing of combat service boots.

(9) Healed disease, injury, or deformity including hyperdactylia which precludes running, is accompanied by disabling pain, or which prohibits wearing of combat service boots.

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

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

(12) 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, or history of surgical correction of same if—

(a) Within the preceding 6 months.

(b) Six months or more have elapsed since operation without recurrence, and there is instability of the knee ligaments in lateral or anteroposterior directions in comparison with the normal knee or abnormalities noted on X-ray, there is significant atrophy or weakness of the thigh musculature in comparison with the normal side, there is not acceptable active motion in flexion and extension, or there are other symptoms of internal derangement.

(2) Authentic history or physical findings of an unstable or internally deranged joint causing disabling pain or seriously limiting function. Individuals with verified episodes of buckling or locking of the knee who have not undergone satisfactory surgical correction or if, subsequent to surgery, there is evidence of more than mild instability of the knee ligaments in lateral and anteroposterior directions in comparison with the normal knee, weakness or atrophy of the thigh musculature in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

d. General.

(1) Deformities of one or both lower extremities which have interfered with function to such a degree as to prevent the individual from following a *physically active* vocation in civilian life or which 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 which interfere with walking, running, or weight bearing.

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

(4) Shortening of a lower extremity resulting in any limp of noticeable degree.

2-11. Miscellaneous

(See also para 2-9 and 2-10.)

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

a. Arthritis.

(1) Active or subacute arthritis, including Marie-Strumpell type.

(2) Chronic osteoarthritis or traumatic arthritis of isolated joints of more than 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.

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

b. *Disease of any bone or joint*, healed, with such resulting deformity or rigidity that function is impaired to such a degree that it will interfere with military service.

c. *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 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.

d. 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 were used for fixation and left in place and which may be subject to easy trauma, i.e., as a plate tibia, etc.

e. *Injury of a bone or joint* within the preceding 6 weeks, without fracture or dislocation, of more than a minor nature.

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

f.1. *Myotonia congenita*. Confirmed.

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

h. *Osteoporosis*.

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

j. *Chondromalacia*, manifested by verified history of joint effusion, interference with function, or residuals from surgery.

Section VIII. EYES AND VISION

2-12. Eyes

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

a. Lids.

(1) Blepharitis, chronic more than mild. 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) Disfiguring cicatrices and adhesions of the eyelids to each other or to the eyeball.

(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 paragraphs 2-40 and 2-41.

(7) Marked inversion or eversion of the eyelids sufficient to cause unsightly appearance or 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. Individuals with acute conjunctivitis are unacceptable until the condition is cured.

(2) Pterygium:

(a) Pterygium recurring after three operative procedures.

(b) Pterygium encroaching on the cornea in excess of 3 millimeters or interfering with vision.

c. Cornea.

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

(2) Keratitis, acute or chronic.

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

★(4) 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 function.

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

(3) Detachment of the retina or history of surgery for same.

(4) Inflammation of the retina (retinitis or other inflammatory conditions of the retina to include Coat's disease, diabetic retinopathy, Eales' disease, and retinitis proliferans).

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).

(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 interfering with visual function (i.e., may suppress).

(2) Diplopia, monocular, documented, interfering with visual function.

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

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

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

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

i. Miscellaneous defects and diseases.

(1) Abnormal conditions of the eye or visual fields due to diseases of the central nervous system.

(2) Absence of an eye.

(3) Asthenopia severe.

(4) Exophthalmos, unilateral or bilateral.

(5) Glaucoma, primary or secondary.

(6) Hemianopsia of any type.

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

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

(9) Night blindness associated with objective disease of the eye. Verified congenital night blindness.

(10) Residuals of old contusions, lacerations.

tions, penetrations, etc., which impair visual function required for satisfactory performance of military duty.

(11) Retained intra-ocular foreign body.

(12) Tumors. See a(6) above and paragraphs 2-40 and 2-41.

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

2-13. Vision

The causes for medical rejection for appointment, enlistment, and induction are listed below. The special administrative criteria for officer assignment to Armor, Artillery, Infantry, Corps of Engineers, Signal Corps, and Military Police Corps are listed in paragraph 7-15.

★*a. Distant visual acuity.* Distant visual acuity of any degree which does 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.

b. Near visual acuity. Near visual acuity of any degree which does not correct to at least J-6 in the better eye.

c. Refractive error. Any degree of refractive error in spherical equivalent of over -8.00 or +8.00; or if ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement, etc.; or if an ophthalmological consultation reveals a condition which is disqualifying.

d. Contact lens. Complicated cases requiring contact lens for adequate correction of vision as keratoconus, corneal scars, and irregular astigmatism.

Section IX. GENITOURINARY SYSTEM

2-14. Genitalia

(See also para 2-40 and 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 which necessitates recurrent absences of more than a few hours from routine activities.

d. Endometriosis, or confirmed history thereof.

e. Hermaphroditism.

f. Menopausal syndrome, either 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.

g. Menstrual cycle, irregularities of, including menorrhagia, if excessive; metrorrhagia; polymenorrhea; amenorrhea, except as noted in *f* above.

h. New growths of the internal or external genitalia except single uterine fibroid, subser-

ous, asymptomatic, less than 3 centimeters in diameter, with no general enlargement of the uterus. See also paragraphs 2-40 and 2-41.

i. Oophoritis, acute or chronic.

j. Ovarian cysts, persistent and considered to be of clinical significance.

k. Pregnancy.

l. Salpingitis, acute or chronic.

m. Testicle(s). (See also para 2-40 and 2-41.)

(1) Absence or nondescent of both testicles.

(2) Undiagnosed enlargement or mass of testicle or epididymis.

(3) Undescended testicle.

n. Urethritis, acute or chronic, other than gonorrheal urethritis without complications.

o. 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.

p. Vagina.

(1) Congenital abnormalities or severe lacerations of the vagina.

(2) Vaginitis, acute or chronic, manifested by leukorrhea.

q. Varicocele or hydrocele, if large or painful.

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 complications (adhesions, disfiguring scars, etc.) residual to surgical correction of these conditions.

2-15. Urinary System

(See para 2-8, 2-40, and 2-41).

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

a. Albuminuria if persistent or recurrent including so-called orthostatic or functional albuminuria.

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

c. Enuresis determine to be a symptom of an organic defect not amenable to treatment. (See also para 2-34c.)

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

e. Hematuria, cylindruria, or other findings indicative of renal tract disease.

f. Incontinence of urine.

g. 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) Hydronephrosis or pyonephrosis.

(5) Nephritis, acute or chronic.

(6) Pyelitis, pyelonephritis.

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.

k. 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.

l. Skeneitis.

m. Urethra.

(1) Stricture of the urethra.

(2) Urethritis, acute or chronic, other than gonorrheal urethritis without complications.

n. Urinary fistula.

o. Other diseases and defects of the urinary system which obviously preclude satisfactory

performance of duty or which 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 which 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 paragraph 2-31.

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

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

d. Depressed fractures near central sulcus with or without convulsive seizures.

e. Loss or congenital absence of the bony substance of the skull not successfully corrected by reconstructive material:

(1) All cases involving absence of the bony substance of the skull which have been corrected but in which the defect is in excess of 1 square inch or the size of a 25 cent piece, will be referred to The Surgeon General together with a report of consultation;

(2) The report of consultation will include an evaluation of any evidence of alteration of brain function in any of its several spheres, i.e., intelligence, judgment, perception, behavior, motor control and sensory function

as well as any evidence of active bone disease or other related complications. Current X-rays and other pertinent laboratory data will accompany such a report of consultation.

f. Unsightly deformities, such as large birthmarks, large hairy moles, extensive scars, and mutilations due to injuries or surgical operations; ulcerations; fistulae, atrophy, or paralysis of part of the face or head.

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-ray is not considered to meet this 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, of any type.

★*d.* (Deleted)

e. 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 so disfiguring as to make the individual objectionable in common social relationships.

f. Spastic contraction of the muscles of the neck, persistent, and chronic.

g. Tumor of thyroid or other structures of the neck. See paragraphs 2-40 and 2-41.

Section XI. HEART AND VASCULAR SYSTEM

2-18. Heart

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

a. All organic valvular diseases of the heart,

including those improved by surgical procedures.

b. Coronary artery disease or myocardial infarction, old or recent or true angina pectoris, at any time.

c. Electrocardiographic evidence of major arrhythmias such as—

(1) Atrial tachycardia, flutter, or fibrillation, ventricular tachycardia or fibrillation.

(2) Conduction defects such as first degree atrio-ventricular block and right bundle branch block. (These conditions occurring as isolated findings are not unfitting when cardiac evaluation reveals no cardiac disease.)

(3) Left bundle branch block, 2d and 3d degree AV block.

(4) Unequivocal electrocardiographic evidence of old or recent myocardial infarction; coronary insufficiency at rest or after stress; or evidence of heart muscle disease.

d. Hypertrophy or dilatation of the heart as evidenced by clinical examination or roentgenographic examination and supported by electrocardiographic examination. Care should be taken to distinguish abnormal enlargement from increased diastolic filling as seen in the well conditioned subject with a sinus bradycardia. Cases of enlarged heart by X-ray not supported by electrocardiographic examination will be forwarded to The Surgeon General for evaluation.

e. Myocardial insufficiency (congestive circulatory failure, cardiac decompensation) obvious or covert, regardless of cause.

f. Paroxysmal tachycardia within the preceding 5 years, or at any time if recurrent or disabling or if associated with electrocardiographic evidence of accelerated A-V conduction (Wolff-Parkinson-White).

★*g. Pericarditis; endocarditis; or myocarditis*, history or finding of, except for a history of a single acute idiopathic or coxsackie pericarditis with no residuals, or tuberculous pericarditis adequately treated with no residuals and inactive for 2 years.

h. Tachycardia persistent with a resting pulse rate of 100 or more, regardless of cause.

2-19. Vascular System

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

a. Congenital or acquired lesions of the aorta and major vessels, such as syphilitic aortitis, demonstrable atherosclerosis which interferes with circulation, congenital or acquired

dilation of the aorta (especially if associated with other features of Marfan's syndrome), and pronounced dilatation of the main pulmonary artery.

b. Hypertension evidenced by preponderant blood pressure readings of 150-mm or more systolic in an individual over 35 years of age or preponderant readings of 140-mm or more systolic in an individual 35 years of age or less. Preponderant diastolic pressure over 90-mm diastolic is cause for rejection at any age.

c. Marked circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, severe peripheral vasomotor disturbances and sympatheticotonia.

d. Peripheral vascular disease including Raynaud's phenomena, Buerger's disease (thromboangiitis obliterans), erythromelalgia, arteriosclerotic and diabetic vascular diseases. Special tests will be employed in doubtful cases.

e. Thrombophlebitis.

(1) History of thrombophlebitis with persistent thrombus or evidence of circulatory obstruction or deep venous incompetence in the involved veins.

(2) Recurrent thrombophlebitis.

f. Varicose veins, if more than mild, or if associated with edema, skin ulceration, or residual scars from ulceration.

2-20. Miscellaneous

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

c. Aneurysm of the heart or major vessel, congenital or acquired.

b. History and evidence of a congenital abnormality which has been treated by surgery but with residual abnormalities or complications, for example: Patent ductus arteriosus with residual cardiac enlargement or pulmonary hypertension; resection of a coarctation of the aorta without a graft when there are other cardiac abnormalities or complications; closure of a secundum type atrial septal defect when there are residual abnormalities or complications.

c. Major congenital abnormalities and defects by the heart and vessels unless satisfactorily corrected without residuals or complications. Uncom-

plicated dextrocardia and other minor asymptomatic anomalies are acceptable.

d. *Substantiated history of rheumatic fever or*

chorea within the previous 2 years, recurrent attacks of rheumatic fever or chorea at any time, or with evidence of residual cardiac damage.

Section XII. HEIGHT, WEIGHT, AND BODY BUILD

2-21. Height

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

a. *For appointment.*

(1) *Men.* Regular Army—Height below 66 inches or over 80 inches. (See administrative criteria in para 7-13.) Other—Height below 60 inches or over 80 inches.

(2) *Women.* Height below 58 inches or over 72 inches.

b. *For enlistments and induction.*

(1) *Men.* Height below 60 inches or over 80 inches for Army and Air Force.

(2) *Men.* Height below 60 inches and over 78 inches for Navy and Marine Corps.

(3) *Women.* Height below 58 inches or over 72 inches.

2-22. Weight

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

a. *Weight related to height* which is below the minimum shown in table I, appendix III for men and table II, appendix III for women.

b. *Weight related to age and height* which is in

excess of the maximum shown in table I, appendix III for men and table II, appendix III for women. See chapter 7 for special requirements pertaining to maximum weight standards applicable to women enlisting for and commissioned from Army Student Nurse and Army Student Dietician Programs.

2-23. Body Build

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

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

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

c. *Evidences of congenital asthenia* (slender bones; weak thorax; visceroptosis; severe, chronic constipation; or “drop heart” if marked in degree).

d. *Obesity.* Even though the individual's weight is within the maximum shown in table I or II, as appropriate, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's weight in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion of prescribed training.

Section XIII. LUNGS AND CHEST WALL

2-24. General

The following conditions are causes for rejection for appointment, enlistment and induction until further study indicates recovery without disqualifying sequelae:

a. *Abnormal elevation of the diaphragm* on either side.

b. *Acute abscess* of the lung.

c. *Acute bronchitis* until the condition is cured.

d. *Acute fibrinous pleurisy*, associated with acute nontuberculous pulmonary infection.

e. *Acute mycotic disease* of the lung such as coccidioidomycosis and histoplasmosis.

f. *Acute nontuberculous pneumonia.*

g. *Foreign body in trachea or bronchus.*

h. *Foreign body of the chest wall* causing symptoms.

i. *Lobectomy*, history of, for a nontuberculous nonmalignant lesion with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.

j. *Other traumatic lesions* of the chest or its contents.

★k. Pneumothorax or history thereof within 1 year of date of examination if due to simple trauma or surgery; within 3 years of date of examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or deformity remains and pulmonary function tests are within normal limits.

sis, tabes dorsalis, meningovascular syphilis).

★*d. Paroxysmal convulsive disorders*, disturbances of consciousness, all forms of psychomotor or temporal lobe epilepsy or history thereof except for seizures associated with toxic states or fever during childhood up to the age of 5.

e. Peripheral nerve disorder.

(1) Polyneuritis.

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

(3) Neurofibromatosis.

f. Spontaneous subarachnoid hemorrhage, verified history of, unless cause has been surgically corrected.

Section XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

2-32. Psychoses

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

Psychosis or authenticated history of a psychotic illness other than those of a brief duration associated with a toxic or infectious process.

2-33. Psychoneuroses

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

a. History of a psychoneurotic reaction which caused—

(1) Hospitalization.

(2) Prolonged care by a physician.

(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 school or work efficiency.

b. History of a brief psychoneurotic reaction or nervous disturbance within the preceding 12 months which was sufficiently severe to require medical attention or absence from work or school for a brief period (maximum of 7 days).

2-34. Personality Disorders

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

a. Character and behavior disorders, as evidenced by—

(1) Frequent encounters with law enforcement agencies, or antisocial attitudes or behavior which, while not a cause for administrative rejection, are tangible evidence of an impaired characterological capacity to adapt to the military service.

(2) Overt homosexuality or other forms of sexual deviant practices such as exhibitionism, transvestism, voyeurism, etc.

(3) Chronic alcoholism or alcohol addiction.

(4) Drug addiction.

b. Character and behavior disorders where it is evident by history and objective examination that the degree of immaturity, instability, personality inadequacy, and 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 symptomatic immaturity reactions 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) and 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.

Section XVII. SKIN AND CELLULAR TISSUES

2-35. Skin and Cellular Tissues

The causes for rejection for appointment, enlistment, and induction 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 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, occasionally 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 which is chronic and resistant to treatment.

f.1 Elephantiasis or chronic lymphedema.

g. Epidermolysis bullosa; pemphigus.

h. Fungus infections, systemic or superficial types: If extensive and not amenable to treatment.

i. Furunculosis. Extensive, recurrent, or chronic.

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

k. Ichthyosis. Severe.

l. Leprosy. Any type.

m. Leukemia cutis mycosis fungoides; Hodgkins' disease.

n. Lichen planus.

o. Lupus erythematosus (acute, subacute, or chronic) or any other dermatosis aggravated by sunlight.

p. Neurofibromatosis (Von Recklinghausen's disease).

q. Nevi or vascular tumors. If extensive, unsightly, or exposed to constant irritation.

r. Psoriasis or a verified history thereof.

s. Radiodermatitis.

t. Scars which are so extensive, deep, or adherent that they may interfere with the wearing of military equipment, or that show a tendency to ulcerate.

u. Scleroderma. Diffuse type.

v. Tuberculosis. See paragraph 2-38.

w. Urticaria. Chronic.

x. Warts, plantar, which have materially interfered with the following of a useful vocation in civilian life.

y. Xanthoma. If disabling or accompanied by hypercholesterolemia or hyperlipemia.

z. Any other chronic skin disorder of a degree or nature which requires frequent outpatient treatment or hospitalization, interferes with the satisfactory performance of duty, or is so disfiguring as to make the individual objectionable in ordinary social relationships.

★*aa.* When in the opinion of the examining physician tattoos will significantly limit effective performance of military service the individual will be referred to the AFEES Commander, for final determination of acceptability.

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

Section I. GENERAL

3-1. Scope

This chapter sets forth the various medical conditions and physical defects which normally 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 US Army regardless of component. (See AR 635-40, AR 135-175, NGR 20-6, and other appropriate regulations for administrative procedures for separation for medically unfit conditions that existed prior to service.)

(2) All enlisted personnel of the US Army regardless of component or duty status. (For those individuals who are found to be medically unfit for entry into service because of an EPTS medical condition or physical defect discovered within the first 4 months of active duty or active duty for training under the Reserve Enlistment Program of 1963, but not medically unfit under this chapter, see paragraph 2-2*b* of this regulation, and AR 635-200.)

(3) Cadets of the United States Military Academy for retention and their subsequent appointment in the regular Army or entry on active duty in enlisted status for whom the standards of this chapter have been made applicable, pursuant to the provisions of paragraph 2-2*e*.

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

(1) Retention of officers, warrant officers

and enlisted personnel (regardless of component) 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 (regardless of component) who have been retired except those retired for temporary disability.

3-3. Policies

★*a.* Normally, members with conditions listed in this chapter will be considered unfit by reason of physical disability; 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 must be decided upon the relevant facts and a determination of fitness or unfitness must be made dependent upon the abilities of the member to perform the duties of his office, grade, rank, or rating in such a manner as to reasonably fulfill the purpose of his employment in the military service. In the case of a finding of fit for duty, any separating or retiring member may request, in writing, a review by the post, camp, station or command surgeon, when the member believes he has a medical condition warranting consideration for physical disability processing. The surgeon will provide a written report of his review on request of the member. A copy of the request and reply will be attached to the members report of medical examination.

b. The various medical conditions and physi-

cal defects which may render a member unfit for military duty by reason of physical disability are not necessarily 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 normally makes an individual unfit because of physical disability if—

(1) The individual is precluded from a reasonable fulfillment of the purpose of his employment in the military service, or

(2) The individual's health or well-being would be compromised if he were to remain in the military service, or

(3) The individual's retention in the military service would prejudice the best interests of the Government.

c. A member will not be declared unfit for military service because of impairments which were known to exist at time of his acceptance for military service, and which have remained essentially the same in degree of severity since acceptance and have not interfered with his 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 (chapter 10, AR 635-40, AR 140-120, and NGR 27) will not necessarily be declared unfit because of physical disability solely because of the defect which caused his special status, when the impairment has remained essentially unchanged and has not interfered with his performance of duty. When his separation or retirement is authorized or required for some other reason, this impairment, like any other, will be evaluated in connection with his processing for separation or retirement.

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 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.

h. Latent impairments will be accorded appropriate consideration both in determining unfitness because of physical disability and in assessing the degree of disability.

i. Every effort will be made to accurately record the physical condition of each member throughout his Army career. A member undergoing examination and evaluation incident to retirement, however, will be judged on actual existing impairments and disabilities with due consideration for latent impairments. It is important, therefore, that all medical conditions and physical defects which are present be recorded, no matter how minor they may appear. Performance of duty despite an impairment will not be considered presumptive evidence of physical fitness.

3-4. Disposition of Members Who May Be Unfit Because of Physical Disability

a. Members who are believed to be unfit be-

cause of physical disability, or who have one of the conditions listed in this chapter, will be processed as prescribed in AR 40-3 and AR 635-40 to determine their eligibility for physical disability benefits under chapter 61, title 10, United States Code. In certain instances, continuance on active duty despite unfitness because of physical disability may be appropriate as indicated below. 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 be retained on active duty and their disability separation or retirement processing deferred for the duration of the mobilization or as directed by the Secretary of the Army. During mobilization, those who are 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 do not meet retention medical fitness standards (mobilization medical fitness standards when these are in effect) will be advised that they may apply for continuance on active duty as provided in chapter 10, AR 635-40. Medical

board action and purely medical criteria (other than medical fitness standards) to be considered in these cases are contained in AR 40-3. Members having between 18 and 20 years of service creditable for retirement who request continuance on active duty will not be processed for physical disability separation or retirement without approval of Headquarters, Department of the Army, despite the recommendation of a medical board to the contrary.

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 25-3, NGR 27, or NGR 62 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 Reserve components who may be unfit because of physical 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

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, con-

sider 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.

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. Arteriosclerotic disease. Associated with myocardial insufficiency (congestive heart failure), repeated anginal attacks, or objective evidence of myocardial infarction.

b. Auricular fibrillation and auricular flutter. Associated with organic heart disease, or if not adequately controlled by medication.

c. Endocarditis. Bacterial endocarditis resulting in myocardial insufficiency or associated with valvular heart disease.

d. Heart block. Associated with other signs and symptoms of organic heart disease or syncope (Stokes-Adams).

e. Myocarditis and degeneration of the myocardium. Myocardial insufficiency at a functional level of class IIC or worse, American Heart Association (app VII).

f. Paroxysmal ventricular tachycardia. If suppressive treatment is required.

g. Paroxysmal supraventricular tachycardia. If associated with organic heart disease or if not adequately controlled by medication.

h. Pericarditis.

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

(2) Chronic serous pericarditis.

i. Rheumatic valvulitis. Cardiac insufficiency at functional capacity and therapeutic level of class IIC or worse as defined by the American Heart Association (app VII). A 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 should be considered unfitting 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.

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, or

b. Coarctation of the aorta. This and other congenital anomalies of the cardiovascular system unless satisfactorily treated by surgical correction.

c. Aneurysms. Aneurysms of any vessel not correctable by surgery and producing limiting symptomatic conditions precluding satisfactory performance of duty. Aneurysm corrected by surgery but with residual limiting symptomatic conditions which preclude satisfactory performance of duty.

- (1) Satisfactory performance of duty is precluded because of underlying, recurring, or progressive disease producing discomfort, dyspnea or similar symptomatic limiting conditions.
- (2) Reconstructive surgery including grafts when:
 - (a) The individual is being evaluated for separation or retirement and the observation period following surgery is deemed inadequate to determine the patient's ability to perform duty as evidenced by a cardiovascular surgical consultation.
 - (b) Prosthetic devices are attached to or implanted in the heart.
 - (c) Unproven procedures have been accomplished and the patient is unable to satisfactorily perform duty or cannot be returned to duty under circumstances permitting close medical supervision of his activities.
- (3) Individual cases not within the criteria above or involving borderline situations, may be referred to The Surgeon General, ATTN: MEDPS-SD for recommendation.

d. Periarteritis 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. Thromboangitis 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 on 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.

d. Residual of surgery of the heart pericardium or vascular system under one or more of the following circumstances: When surgery of the heart, pericardium, or vascular system results in inability of the individual to perform duties without discomfort or dyspnea. When the surgery involves insertion of a pacemaker, reconstructive vascular surgery employing exogenous grafting material, or similar newly developed techniques or prostheses, the individual should be considered unfit.

treatment or remediable measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.

d. *Kyphosis*. More than moderate, interfer-

ing with function, or causing unmilitary appearance.

e. *Scoliosis*. Severe deformity with over two 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.

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.

k. *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 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 3-27d and e.

(2) *Asthma*. See paragraph 3-25a.

(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*. Conditions and defects, individually or in combination, if—

(1) The individual is precluded from a reasonable fulfillment of the purpose of his employment in the military service, or

(2) The individual's health or well-being would be compromised if he were to remain in the military service, or

(3) The individual's retention in the military service would prejudice the best interest of the Government.

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 for a determination of fitness.

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 normally render an individual unfit for further military service.

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. VENEREAL DISEASES

3-40. Venereal Diseases

a. Symptomatic neurosyphilis in any form.

b. Complications or residuals of venereal disease of

such chronicity or degree that the individual is incapable of performing useful duty.

CHAPTER 4

MEDICAL FITNESS STANDARDS FOR FLYING DUTY Short Title: MEDICAL FITNESS STANDARDS FOR FLYING)

Section I. GENERAL

4-1. Scope

This regulation sets forth medical conditions and physical defects which are considered causes for rejection for selection and retention for—

- a. Aircraft mechanics, air traffic controllers, and flight simulator specialists.
- b. Civilian flight instructors.
- c. Participation in regular and frequent aerial flights as nondesignated or nonrated personnel.
- d. Rated Naval aviator, Air Force pilot, or Army aviator or training leading to such designation.

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 standards apply* in the case of individuals being considered for selection for—
 - (1) Aviator training leading to the aeronautical designation of Army aviator, who do not hold a Naval aviator, Air Force pilot or Army aviator rating.
 - (2) ROTC Flight Training Program.
- b. *Class 1A standards apply* in the case of—
 - (1) Individuals being considered for selection for aviator training leading to the aeronautical designation of Army aviator only upon a specific directive by the Department of the Army.
 - (2) Evaluation of individuals selected for training (a(1) above) before such training has begun.

c. *Class 2 standards apply* in the case of—

- (1) FAA rated flight instructors who are to conduct flying instructions at Army aviation training bases.
- (2) Individuals being considered for or performing duty as air traffic controllers.
- (3) Individuals on flying status as a Naval aviator, Air Force pilot, or Army aviator undergoing annual medical examination.
- (4) Rated military pilots being considered for return to duty in a flying status.
- (5) Rated Naval aviators, Air Force pilots, or Army aviators being considered for further flying training.
- (6) Student pilots in military aviation training programs including the ROTC Flight Training Program graduates.
- (7) Test pilots employed by the Department of the Army.

d. *Class 3 standards apply* in the case of individuals ordered by competent authority to participate in regular and frequent aerial flights as nondesignated or nonrated personnel not engaged in the actual control of aircraft, such as aviation medical officers, observers, aircraft mechanics, etc.

4-3. Disposition of Personnel Who Do Not Meet These Standards

a. *Applicants.* The reports of medical examination pertaining to applicants who do not meet the medical fitness standards for flying as prescribed herein will nevertheless be processed for review by the Department of the Army

as prescribed in the appropriate procurement regulation.

b. Rated or designated personnel and non-designated or nonrated personnel. Individuals who do not meet the medical fitness standards for flying as prescribed herein will be immediately suspended from flying as outlined in AR 600-107, 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 the continuance is confirmed, provided the condition is essentially unchanged and that flying safety and the individual's well-being are not compromised.

★*c. Medical consultation service.* A central Army Aviation Medicine Consultation Service (AMCS) is established at the U.S. Army Aviation School, Fort Rucker, Ala. Consultation services are available to unit flight surgeons, command surgeons, and The Surgeon General. 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.
- (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) Other than U.S. Army aviation personnel may be referred to the AMCS provided prior approval of The Surgeon General is obtained.
- (5) Requests for aviation medicine consultation will be forwarded direct to: Commandant, U.S. Army Aviation School, ATTN: Director, Department of Aeromedical Education and Training, Fort Rucker, Ala., 36362.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

4-4. Abdomen and Gastrointestinal System

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are 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 simple catarrhal), and the condition does not appear to be caused by active disease.

b. Functional bowel distress syndrome (irritable colon).

c. Hernia of any variety, other than small umbilical.

d. History of bowel resection for any cause (except appendectomy) and operation for relief of intestinal adhesions. In addition pylorotomy in infancy without complications at present, will not, per se, be cause for rejection.

e. Operation for intussusception except when done in childhood or infancy. Bowel resection in the latter instance will not disqualify examinee.

f. Ulcer.

- (1) *Classes 1 and 1A.* See paragraph 2-3r.
- (2) *Classes 2 and 3.* Until reviewed by The Surgeon General.

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 paragraphs 2-4 and 4-27, plus the following:

Sickle cell trait or sickle cell disease.

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*, including external otitis, until completely healed.
- c. *Deformities of the pinna* if associated with tenderness which may be distracting when constant pressure is exerted.
- d. *History of attacks of vertigo* with or without nausea, vomiting, deafness, and tinnitus.
- e. *Marked retraction of the tympanic membrane* if mobility is limited or if associated with occlusion of the eustachian tubes.
- f. *Post auricular fistula.*
- g. *Radical mastoidectomy.*

h. Recurrent or persistent tinnitus except that personnel under Classes 2 and 3 standards are to be individually evaluated after a period of observation on a nonflying status.

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 at any time.
- (2) *Classes 2 and 3.* Tympanoplasty, until healed with acceptable hearing (app II) and good motility.

4-8. Hearing

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are—

Hearing level 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.

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 paragraphs 2-9, 2-10, 2-11, and 4-23, plus *Limitation of motion*.

a. Classes 1, 1A and 3. Less than full strength and range of motion of all joints.

b. Class 2. Any limitation of motion of any joint which might compromise flying safety.

Section VIII. EYES AND VISION

4-11. Eyes

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-12, plus the following:

- a. Asthenopia of any degree.*
- b. Chorioretinitis* or substantiated history thereof.
- c. Coloboma* of the choroid or iris.
- d. Epiphora.*
- e. Inflammation of the ureal tract;* acute, chronic, or recurrent.
- 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.

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, or
 - (b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set.
 - (c) (Deleted).
 - (2) *Depth perception.*

(a) Any error in lines B, C, or D when using the Machine 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) *Field of vision.*

(a) Any demonstrable scotoma, other than physiologic.

(b) Contraction of the field for form of 15° or more in any meridian.

(5) *Near visual acuity*, uncorrected, less than 20/20 (J-1) in each eye.

(6) *Night vision.* Failure to pass test when indicated by history of night blindness.

(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 six cardinal directions.

(b) Esophoria greater than 10 prism diopters.

(c) Exophoria greater than 5 prism diopters.

(d) Hyperphoria greater than 1 prism diopter.

★(e) Heterotropia, any degree.

★(f) Point of convergence (Pc) greater than 70 mm.

(8) *Power of accommodation* of 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.

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.

c. *Class 2.* Same as Class 1 except as listed below:

(1) *Color vision.*

(a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set (Federal stock No. 6515-388-6606), or

(b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set (Federal stock No. 6515-388-6606), or

(c) Failure to pass the Farnsworth Lantern Test when used in lieu of (a) or (b) above.

(2) *Distant visual acuity.*

★(a) *Control Tower Operator.* Uncorrected that is worse than 20/100 in either eye or such acceptable uncorrected vision that fails to correct with spectacle lenses to 20/20 in each eye.

(b) (Deleted).

★(c) *Pilots.* Uncorrected less than 20/100 in each eye or not correctable with spectacle lenses to 20/20 in each eye.

(3) *Field of vision.* Scotoma, other than physiological unless the pathologic process is healed and which will in no way interfere with flying efficiency or the well-being of the individual.

★(4) *Near visual acuity.* Uncorrected less than 20/100 in each eye or not correctable with spectacle lenses to at least 20/20 in each eye.

(5) *Ocular motility.*

(a) Hyperphoria greater than 1.5 prism.

(b) Failure of the Red Lens Test (suppression or diplopia within 20 inches from the center of the screen in any of the six cardinal directions) until a complete evaluation by a certified ophthalmologist has been forwarded to The Surgeon General for review.

(6) *Refractive error.* No maximum limits prescribed.

d. *Class 3.*

(1) *Color vision.* Same as Class 2, a(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, night vision, depth perception, power of accommodation, ocular motility.* 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. *Class 1 and 1A. Substantiated history of bilateral renal calculi or of repeated attacks of renal or ureteral colic.* Examinees with a his-

tory of a single unilateral attack are acceptable, provided—

(1) Excretory urography reveals no congenital or acquired anomaly.

(2) Renal function is normal.

(3) The calculus has been passed and the

X-ray shows no evidence of concretion in the kidney, ureter, or bladder.

b. *Classes 2 and 3.* A history of renal calculus, unless—

(1) Excretory urography reveals no con-

genital or acquired anomaly.

(2) Renal function is normal.

(3) The calculus has been passed and the X-ray shows no evidence of concretion in the kidney, ureter, or bladder.

Section X. HEAD AND NECK

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; facial paralysis.*

Section XI. HEART AND VASCULAR SYSTEM

4-15. Heart and Vascular System

The causes of 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 atrial tachycardia, nodal tachycardia, atrial flutter, and atrial fibrillation.*

c. *A history of paroxysmal ventricular tachycardia.*

d. *A history of rheumatic fever, or documented manifestation suggestive of rheumatic fever within the preceding 5 years.*

e. *Transverse diameter of heart 15 percent or more greater than predicted by appropriate tables.*

f. *Blood pressure below 90 systolic or 60 diastolic.*

g. *Unsatisfactory orthostatic tolerance test.*

h. *Electrocardiographic.*

(1) Borderline ECG findings until reviewed by The Surgeon General.

(2) Left bundle branch block.

(3) Persistent premature contractions, except in rated personnel when unassociated with significant heart disease or recurrent tachycardia.

(4) Right bundle branch block unless cardiac evaluation reveals the absence of cardiac disease and that the block is presumably congenital.

(5) Short P-R interval and prolonged QRS time (Wolff-Parkinson-White syndrome) or other short P-R interval syndromes predisposing to paroxysmal arrhythmias. In cases involving Class II or Class III examinations, a complete cardiac evaluation including ECG's will be forwarded to The Surgeon General for review.

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.

b. *Class 2, Air Traffic Control, male.* Height below 60 inches or over 76 inches.

c. *Class 2, Air Traffic Control female.* Height below 60 inches or over 72 inches.

d. *Class 3.*

(1) *Female*. Height below 60 inches or over 72 inches.

(2) *Male*. Height below 62 inches or over 76 inches.

4-17. Weight

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are—

a. Weight for males which does not fall within the limits prescribed in table III, appendix III.

b. Weight for females which does not fall within the limits prescribed in table II, appendix III except that maximum weight may not exceed 180 pounds.

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 the predicted vital capacity (app VI).

(c) With a value of less than 75 percent of exhaled predicted vital capacity in 1 second (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*.

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 is within the maximum shown in table III, appendix III, he will be found medically unfit for any flying duty (Classes 1, 1A, 2 and 3) when the medical examiner considers that the excess weight, in relationship to the bony structure and musculature, would adversely affect flying efficiency or endanger the individual's well-being if permitted to continue in flying status.

(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, normal pulmonary function, no additional lung pathology or other contra-indication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 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.

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 over a radio communications system.

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.*

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.

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 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 with sequelae.

Section XV. NEUROLOGICAL DISORDERS

4-23. Neurological Disorders

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-31 and 4-14, plus the following:

a. Classes 1 and 1A.

(1) *A history of infectious meningitis or meningismus* unless it occurred at least 1 year before the examination and the examinee has been without residuals or sequelae for the period beginning 1 month following recovery from the acute phase of the disease.

★(2) *A history of encephalitis*, unless the examinee has been without residuals or sequelae for the period beginning 6 months following recovery from the acute phase of the disease and with current normal EEG and neurological findings.

(3) *Atrophy of an isolated muscle or group*, unless involvement is slight, nonprogressive and of such a nature so as to not interfere with prolonged normal function in any practical manner, as determined by careful history and examination. In addition the onset must have been at least 5 years before the examination.

(4) *A history of fractured skull*, unless unaccompanied by disqualifying sequelae for 1 year with negative physical and laboratory data at the time of the examination.

(5) *Any other organic disease of the central or peripheral nervous system* or definite history of such disease.

(6) *A history of polyneuritis*, unless it occurred at least 5 years prior to the examination and without present symptoms or incapacity.

(7) *Craniocerebral injury*, defined as any trauma to the head, with—

(a) *Unconsciousness*, unless shorter than 2 hours in duration and if multiple episodes, shorter than 2 hours combined duration.

(b) *Amnesia*, unless shorter than 4 hours in duration.

(c) *Change in personality or deterioration of intellect.*

(d) *Craniotomy.*

(e) *Depressed fracture or absence of bony substance of the skull.*

(f) *Focal neurological signs* such as paralysis, weakness, disturbance of sensation, or convulsive seizure.

(g) *Post-traumatic headache*, unless shorter than 3 months in duration.

Examinees with complications other than those listed above, are not necessarily acceptable. In general the decision must be based upon the following: The duration of symptoms such as unconsciousness or amnesia; the time elapsed since the injury; and the clinical and laboratory findings; including X-ray of the skull, electroencephalography, caloric study of vestibular function, report of the attending physician, and complete neurological examination. Examinees with a history of a single brief period of unconsciousness or amnesia (less than 15 minutes) because of head injury are acceptable at any time, but special circumstances may indicate need for a complete neurological survey or delay of 1 year from the time of the accident to permit questionable sequelae to develop or to recede. Any individual with unconsciousness or amnesia or more than 15 minutes duration at any time should not be accepted within a year of the injury and then only after a detailed neurological study.

- (8) *Epilepsy or convulsive disorder* of any type other than during febrile illnesses of childhood.
- (9) *Isolated neuritis* occurring within the 5 years preceding the examination, unless the cause is definitely determined and found to be no basis for future concern and examination reveals no or only minimal residuals considered inconsequential from the standpoint of duty contemplated.
- (10) *Migraine or migrainous type of headache* occurring repeatedly and of sufficient intensity as to incapacitate temporarily the examinee for his usual pursuits or to require regular medications.
- (11) *Poliomyelitis*, unless it occurred over 1 year prior to the date of the examination and shows no residuals.

b. Classes 2 and 3.

- (1) *Active disease of the nervous system* of any type. Upon arrest of the active disease, individual evaluation will be made

as to qualification for return to flying duty. Questionable cases will be referred to higher headquarters with complete documentation for final decision.

- (2) *Craniocerebral injury* until the provisions outlined in *a(7)* above are fulfilled. If there is reason to believe that focal brain injury or dural damage has occurred, seizures may follow and suspension should be for at least 1 year following the injury. Such damage may be expected when depressed fractures, penetrating injuries, amnesia lasting several hours, prolonged unconsciousness, or focal neurological findings have occurred. A craniotomy for any cause should be followed likewise by a period of at least 1 year of ground duty only. Should convulsions or other serious sequelae or complications appear, suspension from flying must be indefinite.
- (3) *Epilepsy or convulsive disorder* of any type rather than during acute febrile illness of childhood.

Section XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

★4-24. Psychoses, Psychoneuroses, and Personality Disorders

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3, are the causes listed in paragraphs 2-32, 2-33, 2-34, and 4-27d plus the following:

a. 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.

b. Character behavior disorders. See AR 40-401.

c. Enuresis after age 10, repeated.

d. Excessive use of alcohol or drugs which has interfered with the performance of duty.

e. Fear of flying when a manifestation of a psychiatric illness. Refusal to fly or fear of flying

not due to a psychiatric illness is an administrative problem.

f. Habit spasm, stammering or stuttering of any degree after age 10.

g. History of psychosis or attempted suicide at any time.

h. Insomnia, severe and prolonged.

i. Night terrors, severe, repeated.

j. Obsessions, compulsions, aerophobia, and phobias which influence behavior materially.

k. Psychogenic amnesia at any time.

l. Psychoneurosis (see AR 40-401) when more than mild and incapacitating to any degree at any time.

m. Somnambulism, multiple (2 or more) instances after age of 10 or an episode within 1 year preceding the examination.

n. Vasomotor instability.

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 paragraph 2-35.

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 2-36 and 2-37, 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) *Healed fracture or dislocation of the vertebrae.*

(3) *Lateral deviation of the spine from the normal midline of more than 1 inch (scoliosis), asymptomatic.*

b. Classes 2 and 3. Any of the conditions listed in a above of such a nature or degree as to compromise flying safety.

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 2-38 and 2-39 plus the following:

*a. Antihistamines or barbiturate medication—*Classes 1, 1A, 2, and 3. While individuals are undergoing treatment with any of the antihistamines or barbiturate preparations.

b. Blood donations. Classes 1, 1A, 2, and 3. Personnel on flying status will not perform flying duties for a period of 72 hours following the donation of blood.

c. Malaria:

- (1) *Classes 1, 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 cells are normal in numbers and structure, and the blood hemoglobin is at least 12 grams percent.
 - (c) A thick smear (to be done if the disease occurred within 1 year of the examination) is negative for parasites.
- (2) *Classes 2 and 3.* A history of malaria unless adequate therapy, in accordance with existing directives, has been completed. The duration of suspension is an individual problem and will vary with the type of malaria, the severity of infection, and the response to treatment.

However, personnel may not fly unless afebrile for 7 days, the red cells are normal in number and structure, the blood hemoglobin is at least 12 grams percent, and the thick smear (to be done if the disease occurred within 1 year of the examination) is negative for parasites. A thick smear and a medical examination will be made every 2 weeks for at least 3 months after all antimalarial therapy has been stopped.

*d. Mood-ameliorating, tranquilizing, or ataraxic drugs—*Classes 1, 1A, 2 and 3—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.

*e. Motion sickness—*Classes 1 and 1A—History of motion sickness, other than isolated instances without emotional involvement, or history of previous elimination from flight training at any time by reason of airsickness.

f. Other diseases and conditions which, based on sound medical principles, will in any way interfere with the individual's health and well-being or compromise flying safety.

g. Sarcoidosis:

- (1) Classes 1, 1A and 3—A history of sarcoidosis even if in remission.
- (2) Class 2—Sarcoidosis except when in remission, asymptomatic, and there is no loss of functional capacity.

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 paragraphs 2-40 and 2-41.

b. Classes 2 and 3. Except in the case of individuals being processed for disability separation in accordance with paragraph 3-4, individuals having a malignant disease or tumor will be considered as medically unfit pending review and evaluation by The Surgeon General.

Section XXI. VENEREAL DISEASES

4-29. Venereal 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 directives current at the time of the examination, or the equivalent thereof, have been fulfilled.
- (3) Examination of the spinal fluid reveals a negative serologic test for syphilis, and a cell count and content of protein are within normal limits.

- (4) The individual concerned has been clinically cured with no evidence of recurrence for a period of 1 year subsequent to treatment.

b. Class 3:

- (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.*

Section XXII. ADAPTABILITY RATING FOR MILITARY AERONAUTICS (ARMA)

4-30. Adaptability Rating for Military Aeronautics (ARMA)

(See TB Med 244.)

This requirement exists only for Classes 1 and 1A and for selection of Air Traffic Controllers under Class 2 standards.

The cause of medical unfitness for flying duty, Classes 1 and 1A is—

Unsatisfactory ARMA whether due to failure to meet the medical fitness criteria contained herein, failure to meet prescribed minimum aptitude or psychological factors or otherwise is considered not to be adaptable for military aeronautics.

CHAPTER 5

MEDICAL FITNESS STANDARDS FOR ADMISSION TO U.S. MILITARY ACADEMY

(Short Title: USMA MEDICAL FITNESS STANDARDS)

Section I. GENERAL

5-1 Scope

This chapter sets forth medical conditions and physical defects which are causes for rejection for admission to the US Military Academy.

5-2. Applicability

The causes for rejection for admission to the US Military Academy are all of the causes list-

ed in chapter 2, plus all of the causes listed in this chapter. These standards and the medical fitness standards contained in chapter 2, as further restricted herein, apply to—

- a. All candidates and prospective candidates for the Military Academy.
- b. All *ex-cadets* under consideration for readmission as a Cadet of the US Military Academy.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

5-3. Abdomen and Gastrointestinal System

The causes of medical unfitness for USMA are

the causes listed in paragraph 2-3 plus the following: *Hernia* of any variety.

Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

5-4. Blood and Blood-Forming Tissue Diseases

The causes of medical unfitness for USMA are

the causes listed in paragraph 2-4.

Section IV. DENTAL

5-5. Dental

The causes of medical unfitness for USMA are—

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

b. *Jaws*. Relationship between the mandible and maxilla of such nature as to preclude satisfactory prosthodontic replacements should it become necessary to remove any or all of the remaining natural teeth.

c. *Prosthodontic appliances*.

- (1) Appliances below generally accepted

standards of design, construction, and tissue adaptation.

- (2) Lower appliance which is not retained or adequately stabilized by sufficient serviceable natural teeth.

d. *Teeth*.

- (1) Carious natural teeth which are unfilled or improperly filled.

- (2) Grossly disfiguring spacing of existing anterior teeth.

- (3) Insufficient upper and lower serviceable anterior and posterior natural or artificial teeth functionally opposed to permit mastication of normal diet.

Section V. EARS AND HEARING

5-6. Ears

The causes of medical unfitness for USMA are the causes listed in paragraph 2-6, plus the following:

- a. *Abnormalities* which are disfiguring or incapacitating.
- b. *Disease*, acute or chronic.
- c. *Perforation of the tympanic membrane*, regardless of etiology.

5-7. Hearing

The causes of medical unfitness for USMA are—Hearing acuity level by audiometer testing (regardless of conversational or whispered voice hearing acuity) greater than that prescribed in table III, appendix II.

Section VI. ENDOCRINE AND METABOLIC DISORDERS

5-8. Endocrine and Metabolic Disorders

The causes of medical unfitness for USMA are the causes listed in paragraph 2-8.

Section VII. EXTREMITIES

5-9. Upper Extremities

The causes of medical unfitness for USMA are the causes listed in paragraphs 2-9 and 2-11, plus the following:

★a. *Absence of one phalanx of any finger in association with the absence of the little finger of the same hand.*

b. *Any deformity or limitation of motion which precludes the proper accomplishment of the hand salute or manual of arms, which detracts from smart military bearing or appearance, or which would interfere with daily participation in a rigorous physical training or athletic program.*

5-10. Lower Extremities

The causes of medical unfitness for USMA are

the causes listed in paragraphs 2-10 and 2-11, plus the following:

a. *Any deformity or limitation of motion which interferes with the proper accomplishment of close order drill, which detracts from a smart military bearing or appearance, or which would interfere with daily participation in a rigorous physical training or athletic program.*

b. *Flatfoot*, symptomatic, or with marked bulging of the inner border of the astragalus.

c. *Pes cavus* with clawing of the toes and caluses beneath the metatarsal heads.

d. *Shortening of a lower extremity* which requires a lift or when there is any perceptible limp.

Section VIII. EYES AND VISION

5-11. Eyes

The causes of medical unfitness for USMA are the causes listed in paragraph 2-12, plus the following:

a. *Any acute or chronic disease of the eye or adnexa.*

b. *Any disfiguring or incapacitating abnormality.*

c. *Ocular mobility and motility.*

- (1) Esophoria of over 15 prism diopters.
- (2) Exophoria of over 10 prism diopters.
- (3) Hyperphoria of over 2 prism diopters.
- (4) Strabismus of any degree.

5-12. Vision

The causes of medical unfitness for USMA are the causes listed in paragraph 2-13, plus the following:

a. *Color blindness.* Inability to distinguish

Section III. MEDICAL FITNESS STANDARDS FOR ARMY SERVICE SCHOOLS

★7-5. 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 350-10.

Section IV. MEDICAL FITNESS STANDARDS FOR DIVING TRAINING AND DUTY

7-6. Medical Fitness Standards for Initial Selection for Diving Training

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) Tendency to flatulence.
- (3) Hernia of any variety.
- (4) Operation for relief of intestinal adhesions at any time.
- (5) Gastrointestinal disease of any type.
- (6) Chronic or recurrent gastrointestinal disorder.
- (7) Laparotomy within the preceding 6 months.

b. Blood and blood-forming tissue diseases.

- (1) Paragraph 2-4.
- (2) Sickle cell trait or sickle cell disease.

c. Dental.

- (1) Paragraph 2-5.
- (2) Any oral disease until all infection and any conditions which contribute to recurrence are eradicated.
- (3) Any unserviceable teeth until corrected.

d. Ears and hearing.

- (1) Paragraph 2-6.
- (2) Perforation, marked scarring or thickening of the ear drum.
- (3) Inability to equalize pressure on both sides of the ear drums while under 50 pounds of pressure in a compression chamber.
- (4) Acute or chronic disease of the auditory canal, tympanic membrane, middle or internal ear.
- (5) Hearing acuity level in either ear by audiometric testing (regardless of conversa-

tional or whispered voice hearing acuity) which exceeds 15 decibels at any of the frequencies 256, 512, 1024, 2048, or which exceeds 40 decibels at frequency 4096.

(6) History of otitis media or otitis externa at any time.

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.
- (3) Loss of any digit of either hand.
- (4) Fracture or history of disease or operation involving any major joint.
- (5) Any limitation of the strength or range of motion of any of the extremities.

g. Eyes and vision.

- (1) Paragraph 2-12.
- (2) Distant visual acuity, uncorrected, of less than 20/40 in each eye.

★(3) *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.

(4) Abnormalities of any kind noted during ophthalmoscopic examination.

h. Genitourinary system.

- (1) Paragraphs 2-14 and 2-15.
- (2) Chronic or recurrent genitourinary disease or complaints.
- (3) Abnormal findings by urinalysis.

i. Head and neck. Paragraphs 2-16, 2-17, and 4-16h.

j. Heart and vascular system.

- (1) Paragraphs 2-18, 2-19, and 2-20.
- (2) Varicose veins of any degree.

- (3) Marked or symptomatic hemorrhoids.
- (4) Persistent tachycardia or arrhythmia except of sinus type.

k. Height: No special requirement.

l. Weight.

(1) Weight related to height which is below the minimum shown in table IV, appendix III.

(2) Weight related to height which is above the maximum shown in table IV, appendix III.

m. Body build.

(1) Paragraph 2-23.

(2) Obesity of any degree.

n. Lungs and chest wall.

(1) Paragraphs 2-24, 2-25, and 2-26.

(2) History of tuberculosis, asthma, or chronic pulmonary disease, or chest or lung operation at any time.

(3) Any pulmonary disease at the time of examination.

(4) Inability to hold breath for 60 seconds subsequent to deep breathing.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus.

(1) Paragraphs 2-27, 2-28, 2-29, and 2-30.

(2) History of chronic or recurrent sinusitis at any time.

(3) Any nasal obstruction or sinus disease at the time of examination.

(4) Chronically diseased tonsils until removed.

p. Neurological disorders.

(1) Paragraph 2-31.

(2) The special criteria which are outlined in paragraph 4-24 for Class 1 flying duty are also applicable to diving duty.

q. Psychoses, psychoneuroses, and personality disorders.

(1) Paragraphs 2-32, 2-33, and 2-34.

(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 2-36 and 2-37.

(2) Spondylolysis, spondylolisthesis.

(3) Healed fractures or dislocations of the vertebrae.

(4) Lumbosacral or sacroiliac strain, or any history of a disabling episode of back pain, especially when associated with significant objective findings.

t. Systemic diseases and miscellaneous conditions and defects.

(1) Paragraphs 2-38 and 2-39.

(2) Any severe illness, operation, injury, or defeat of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe diving.

u. Tumors and malignant diseases. Paragraphs 2-40 and 2-41.

v. Venereal disease.

(1) Active venereal disease or repeated venereal infection.

(2) History of clinical or serological evidence of active or latent syphilis within the past 5 years or of cardiovascular or central nervous system involvement at any time.

7-7. Medical Fitness Standards for Retention for Diving Duty

The medical fitness standards contained in paragraph 7-6 apply to all personnel performing diving duty except that divers of long experience and a high degree of efficiency—

a. May be permitted a moderate degree of *overweight* if the individual is otherwise vigorous and active.

b. Must be free from disease of the auditory, cardiovascular, respiratory, genitourinary and gastrointestinal system.

c. Must maintain their ability to equalize air pressure.

d. Uncorrected visual acuity of not less than 20/40 in the better eye.

**Section V. MEDICAL FITNESS STANDARDS FOR ENLISTED
MILITARY OCCUPATIONAL SPECIALTIES**

**7-8. 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 pur-

pose 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

7-9. 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 *d* below.

c. Rescinded.

d. MAAG's, 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 MAAG's, military attachés, military missions, or any type duty in isolated overseas stations requiring residence in areas where US military 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 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 from CONUS.

(4) Findings and recommendations of the examining physicians and dentists will be based entirely on the examination and a review of the Health Record, outpatient, or inpatient medical records. Motivation of the examinee *must* be minimized and recommendations based only on the professional judgment of the examiners.

e. The medical fitness standards set forth in *d* above are prescribed for the purpose of meeting selection criteria for military personnel under consideration for assignment or attachment to duty with MAAG's, 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 U.S. MILITARY ACADEMY

7-10. Medical Fitness Standards for Admission to U.S. 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, U.S. Navy as well as NAVPERS 15.010 Regulations Governing the Admission of Candi-

dates into the United States Naval Academy as Midshipmen.

7-11. Medical Fitness Standards for Admission to U.S. 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.

Section VIII. SPECIAL ADMINISTRATIVE CRITERIA APPLICABLE TO CERTAIN MEDICAL FITNESS REQUIREMENTS

The special administrative criteria in paragraphs 7-12 through 7-15 are listed for the information and guidance of all concerned.

★7-12. 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 AFEEES 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, Hampton, Virginia 23359, to HQDA (DASG-HES-P), WASH DC 20314, for final determination of acceptability. The Surgeon General will coordinate, as appropriate, with the Surgeon General, US Air Force or the Chief, Bureau of Medicine and Surgery, Department 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 8 of this regulation.

b. Applicants for appointment to the United States Military Academy, and the several programs of the Army ROTC are acceptable with orthodontic appliances.

c. Officers and enlisted personnel of all components are acceptable for active duty, or active duty for training under the Reserve Enlistment Program of 1963, if the orthodontic appliances were affixed 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 with retainer orthodontic appliances who are not required to undergo active treatment are administratively acceptable for appointment, enlistment or induction.

7-13. Height—Regular Army Commission (See para 2-21a(1).)

The following applies to all males being considered for a Regular Army commission:

a. Individuals being considered for appointment in the Regular Army in other than Armor, Artillery, or Infantry who are not more than 2 inches below the minimum height requirement of 66 inches *will automatically* be

considered on an individual basis for an administrative waiver by Headquarters, Department of the Army during the processing of their applications.

b. Individuals being considered for appointment in the Regular Army in Armor, Artillery, or Infantry who are not more than 2 inches below the minimum height requirement of 66 inches *will automatically* be considered for an administrative waiver by Headquarters, Department of the Army during the processing of their applications provided they have outstanding abilities, military records, or educational qualifications.

7-14. Height—United States Military Academy

(See para 5-16.)

The following applies to all male candidates to the United States Military Academy:

Candidates for admission to the United States Military Academy who are over the maximum height of 80 inches or below the minimum height of 66 inches will automatically be recommended by The Surgeon General 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 qualification, have an outstanding military record, or have demonstrated outstanding abilities.

★7-15. Vision—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 Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps may possess uncorrected distant 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.

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 age and grade.

(2) The officer's medical fitness for retention in Army service shall be determined pursuant to chapter 3 including paragraph 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.

7-16. Weight—Enlistment in WAC for Student Nurse Program and Student Dietitian Program and Appointment Therefrom

The medical fitness standards for initial selection as members of the Women's Army Corps for Training under the Army Student Nurse and the Army Student Dietitian Programs, and for commissioning from these programs are set forth in chapter 2 except that the maximum weight standards set forth in table II, appendix III may be exceeded by 10 percent.

**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)**

**7-17. 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 7-9d.
- 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 (for individuals of susceptible groups).
- (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**

7-18. Standards

When so directed in special procurement programs prescribed by the Department of the Army, active duty officers and enlisted men possessing current valid FAA private pilot certificates or higher certificates may be medically qualified for initial Army aviation flight training under the following modified medical fitness standards. Class 1A medical fitness standards for flying duty as prescribed in chapter 4 except—

★a. *Vision*. Uncorrected distant visual acuity less than 20/100 in each eye, or not corrected with spectacle lenses to 20/20 in each eye. Uncorrected near visual acuity less than 20/100 in each eye, or not correctable with spectacle lenses to 20/20 in each eye.

b. *Refractive error*.

(1) *Astigmatism*. Not more than 1.00 diopter.

(2) *Hyperopia*. Not more than 1.75 diopters under age 35 and not more than 2.00 diopters over age 35 in any meridian.

(3) *Myopia*. Not more than 1.25 diopters in any meridian regardless of age.

★7-19. 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 diopeter.

(b) *Hyperopia.* Greater than 1.75 diopters for individuals under the age of 35

years and greater than 2.00 diopter for individuals age 35 and over, in any meridian.

(c) *Myopia.* Greater than 1.25 diopters in any meridian regardless of age.

b. Unsatisfactory ARMA.

CHAPTER 8
MEDICAL FITNESS STANDARDS FOR PHYSICIANS, DENTISTS,
AND ALLIED MEDICAL SPECIALISTS
(Short Title: MEDICAL SPECIALISTS MEDICAL FITNESS STANDARDS)

Section I. GENERAL

8-1. Scope

This chapter sets forth the minimum level of medical fitness standards for physicians, dentists, and allied medical specialists.

8-2. Applicability

a. These standards apply only in evaluating physicians, dentists, or allied medical specialists for—

(1) Induction.

(2) Appointment in other than the regular component of the Armed Forces.

(3) Entry on active duty or active duty for training as an officer or an enlisted member of a component of the Armed Forces other than regular.

★(4) Retention as an officer or enlisted member in any component of the Armed Forces, until such time as such an individual has completed his Selective Service or contractual obligation of active duty whichever is longer. After such time, an individual's fitness for service will be determined by the Standards of chapter 3 of this regulation, although Voluntary Waivers may be granted as set forth in chapter 3.

b. These standards are not applicable to an individual who is over 35 years of age or who is otherwise exempt from training and service under the Military Selective Service Act.

8-3. Department of Defense Policy

The policy of the Department of Defense regarding the medical fitness criteria is that—

a. Physicians, dentists, and allied medical specialists are considered to be potentially acceptable for military service provided they can reasonably be expected to be productive in the Armed Forces.

b. Physicians, dentists, and allied medical specialists with static impairments and those with chronic progressive or recurrent diseases, if asymptomatic or relatively so, are considered acceptable for military service.

8-4. Questionable Cases

Questionable cases involving the diagnoses listed below will be referred in accordance with current procedures to The Surgeon General, ATTN: MEDPS-SP, Department of the Army, for an opinion of acceptability prior to qualification.

a. *Congenital abnormalities of heart and great vessels.*

b. *Hernia (only those cases considered irreparable).*

c. *Peptic ulcer.*

d. *Psychoneuroses and psychoses.*

e. *Tuberculosis.*

f. *Nephrolithiasis.*

Section II. MEDICAL FITNESS STANDARDS

8-5. Basic Medical Fitness Standards

a. The nature of the duties expected of physicians, dentists and allied medical specialists is such, in general, that although they may

have physical defects or medical conditions which would ordinarily be cause for rejection for original entry into the military service, they may be expected to perform appropriate

military duties in their specialties.

★*b.* The causes of medical unfitness for the purposes prescribed by paragraph 8-2 are the various medical conditions and physical defects which normally render a member unfit for further military service contained in chapter 3 of this regulation as modified by this chapter.

8-6. Abdomen and Gastrointestinal System

The causes of medical unfitness for physicians, dentists and allied medical specialists are—

- a.* Paragraphs 3-5 and 3-6.
- b. Amebiasis.* A history of amebiasis when active hepatic involvement is present.
- c. Anal fistula* with extensive multiple sinus tracts.
- d. Chronic cholecystitis or cholelithiasis* if disabling for civilian practice.
- e. Liver disease.* A history of liver disease when presence of liver disease is manifested by hepatomegaly or abnormal liver function studies. If disease is considered temporary: Deferment for reexamination at a later date.
- f. Peptic ulcer.* A history of peptic ulcer complicated by obstruction, verified history of perforation, or recurrent hemorrhage is disqualifying. An individual with X-ray evidence of an active ulcer will be deferred for reexamination at a later date. A history of peptic ulcer or a healed ulcer, with scarring but without a niche or crater as demonstrated by X-ray, is acceptable.
- g. Splenectomy.* A history of splenectomy except when the surgery was for trauma, surgery unrelated to disease of the spleen, hereditary spherocytosis, or disease involving the spleen where splenectomy was followed by correction of the condition for a period of at least 2 years.
- h. Ulcerative colitis.* Confirmed by proctosigmoidoscopic or X-ray findings.

8-7. Blood and Blood-Forming Tissue Diseases

The causes of medical unfitness for physicians,

dentists, and allied medical specialists are the same as those listed in paragraph 3-7, except that splenomegaly is not disqualifying per se, however, its underlying causes may be disqualifying.

8-8. Dental

The causes of medical unfitness for physicians, dentists, and allied medical specialists are the same as those listed in paragraph 3-8.

8-9. Ears and Hearing

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

- a.* Paragraph 3-9.
- b. Auditory acuity.* Hearing which cannot be improved in one ear with a hearing aid to an average hearing level of 20 decibels or less in the speech reception range. Unilateral deafness is not disqualifying.
- c. Meniere's syndrome.* An individual who suffers Meniere's syndrome is disqualified when he has severe recurring attacks which cannot be controlled by treatment or requires hospitalization of sufficient frequency to interfere materially with civilian practice.
- d. Otitis media,* if chronic, suppurative, resistant to treatment, and necessitating hospitalization of sufficient frequency to interfere materially with civilian practice.

8-10. Endocrine and Metabolic Diseases

The causes of medical unfitness for physicians, dentists, and allied medical specialists are the causes listed in paragraph 3-11.

8-11. Extremities

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

- a.* Paragraphs 3-12, 3-13, 3-14, and 8-22.
- b. Amputation of leg or thigh* if suitable prosthesis is not available or if the use of a cane or crutch is required.
- c. Weight bearing joints.* Inability to bear weight. Instability of a weight bearing joint or any disease processes of weight bearing joints requiring use of a cane or crutch.

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to The Surgeon General, ATTN: MEDPS-SP, Department of the Army, for an opinion of acceptability prior to qualification.

★*c.* *Psychosis* of organic or functional etiology

except if in complete remission for 2 years or more. Neuropsychiatric consultation, in addition to Standard Forms 88 and 93, will be sent to The Surgeon General, ATTN: MEDPS-SP,

Department of the Army, Washington, D.C. 20315, for an opinion of acceptability prior to qualification.

8-21. Skin and Cellular Tissues

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraph 3-33.

b. *Chronic dermatitis* more than mild in degree, generalized, requiring frequent outpatient treatment or hospitalization or if it has been resistant to prolonged periods of treatment.

c. *Pilonidal cysts* are acceptable.

8-22. Spine, Scapulae, Ribs and Sacroiliac Joints

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. The causes listed in paragraph 3-34.

b. *Intervertebral disc syndrome* when there are definite objective abnormal findings on physical examination.

c. *Osteoarthritis*. When there is persistent pain and limited function associated with objective X-ray evidence and documented history of recurrent incapacity for prolonged periods.

d. *Scoliosis* when the deformity is so marked as to be apparent and objectionable when wearing the uniform.

e. *Spondylolysis, spondylolisthesis* or other congenital anomalies of the spine with significant recurrent symptoms on moderate or normal activity.

8-23. Systemic Diseases and Miscellaneous Conditions and Defects

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. The causes listed in paragraphs 3-25 and 3-26.

b. *Tuberculosis*.

(1) Pulmonary tuberculosis. See paragraph 8-17h.

(2) Active tuberculosis of a bone or joint or a verified history of tuberculosis of a bone or joint.

c. *Sarcoidosis*. See also paragraph 8-17f.

8-24. Tumors and Malignant Diseases

The causes of medical unfitness for physicians, dentists and allied medical specialists are—

a. The causes listed in paragraphs 3-37, 3-38, and 3-39.

b. *Malignant growths* are generally disqualifying. Those which have been entirely removed without evidence of metastasis, which are of a type from which a "cure" may be expected after removal, and which have had adequate followups are acceptable.

8-25. Venereal Diseases

The causes of medical unfitness for physicians, dentists, and allied medical specialists are listed in paragraph 3-40.

★*b.* Each individual whose functional capacity has changed will be interviewed as indicated below and, if necessary, examined by a medical profiling officer to ascertain whether or not the recorded physical profile serial is a true reflection of his actual functional capacity. If the individual's unit commander or a personnel management officer is available, he or they should assist the profiling officer, when requested, in verifying and/or recommending revision of the profile. 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 his ability to perform duty. Except as indicated in *e* and *h* below, permanent revision of profile from or to a numerical designator "3" or "4" will be accomplished by a medical board when, in the opinion of the profiling officer, the functional capacity of the individual has changed to such an extent that it permanently alters his functional ability to perform duty. Whenever a medical board is held for the sole purpose of permanently revising the physical profile to or from a numerical designator "3" the Medical Condition, Physical Profile Record (DA Form 3349) (fig. 9-1) will be used in lieu of the Medical Board Proceedings (DA Form 8-118). Medical Board officers and the approving authority will complete the appropriate items on reverse of DA Form 3349. When the profile serial is revised, the revision will be submitted to the individual's unit commander on a DA Form 3349. This will permit proper coding by personnel officers as outlined in paragraph 9-5 and reclassification and assignment in keeping with the individual's physical and mental qualifications. If, in the opinion of the medical profiling officer, the functional capacity of the individual has not been fundamentally changed at the time of verification, no revision of the profile will be necessary, and the unit commander will be appropriately informed.

c. Physical profiles will be verified as follows:

(1) *Hospitals and other medical treatment facilities.* Prior to a patient's return to duty

upon completion of hospitalization, regardless of duration (the profile of patients hospitalized over 6 months will be verified by a medical board) and at the time service members undergo periodic, active duty, or active duty for training medical examinations or whenever a significant change in functional ability is believed to have occurred.

(2) *Unit and organizations.*

(a) Any time during training of new enlistees or inductees that such action appears warranted.

(b) Upon request of the unit commander.

(c) At the time of the periodic medical examination.

★*d.* Except as noted in *f* below, an individual on active duty having a modifier "R" or "T" will have his profile reviewed at least every 3 months in order to insure that it reflects his current functional capability. Unit commanders/personnel officers are responsible for the initiation of this review (except when the individual is hospitalized).

e. Individuals being returned to a duty status pursuant to the approved findings of a physical evaluation board, the Army Physical Review Council or the Army Physical Disability Appeal Board under AR 635-40, will be given a physical profile commensurate with their functional capacity under the appropriate factor by The Surgeon General, Department of the Army. Assignment limitations will be established concurrently. All such cases will be referred to The Surgeon General, ATTN: MEDPS-SD by The Adjutant General 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 revised by a medical board if the individual's functional capacity warrants such action.

f. Tuberculous patients returned to a duty status who require antituberculous chemotherapy following hospitalization will be given a P-3-T profile for a period of 1 year with recommendation that the member be placed on duty at a fixed installation and will be pro-

vided the required medical supervision for a period of 1 year.

g. The physical profile in controversial or equivocal cases may be verified or revised by a medical board, hospital commander, or major command surgeon, who may refer unusual cases, when appropriate, to The Surgeon General for final determination of an appropriate profile.

h. Revision of the physical profile for reservists not on active duty will be accomplished by the surgeon of the major command without medical board procedure. For members of the Army National Guard not on active duty, such profile revision will be accomplished by the unit medical officer or the state Surgeon. See NGR 27.

★9-9. Separation of Individuals With a Modifier "R" "S" or "T" or a Code "V" or "W"

a. Individuals whose period of service expires and whose physical profile contains the modifier "R" "S" or "T" will undergo appropriate medical evaluation to determine the desirability of termination of the modifier. In those instances where the termination of the modifier is not deemed appropriate, the procedure in AR 635-200 will be followed in the case of enlisted personnel and AR 635-100 in the case of officer personnel.

b. Individuals whose period of service expires and whose physical profile code is "W" will appear before a medical board to determine if processing as provided in paragraphs 3-3 and 3-4 is indicated.

c. Individuals whose period of service expires and whose physical profile code is "V" will appear before a medical board for processing as provided in paragraph 3-4.

9-10. Assignment Restrictions, or Geographical or Climatic Area Limitations

Paragraph 7-9 establishes that personnel fit for continued military status are medically fit for duty *on a worldwide basis*. Assignment restrictions or geographical or climatic area limi-

tations are contained in paragraph 9-5 and on the reverse of DA Form 3349 (Medical Condition—Physical Profile Record). 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 no geographic assignment limitations normally 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 significant assignment restrictions, or geographical or climatic area limitations associated with a physical profile identified with one or more numerical designator "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" when the individual is on active duty.

e. Permanent assignment limitations under peacetime conditions (AR 40-3) normally will be established only by a medical board. Individuals accepted for military service under the provisions of chapter 8 will have assignment limitations established by the AFEEES profiling officer.

f. Permanent geographical or climatic area assignment limitations may be removed or modified only by a medical board.

g. In every instance each medical condition or physical defect causing an assignment limitation will be identified in nontechnical language.

h. Assignment restrictions or geographical

cal officers on request of an aviation medical officer or flight surgeon. However, in all such instances, the Standard Forms 88 and 93 must be reviewed and signed by the aviation medical officer or flight surgeon.

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 27, 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 an Armed Forces examining and entrance station) 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 authorized.

h. When required and/or indicated by the examining physician, enlisted medical personnel or civilian employees properly qualified by training and experience may conduct the following phases of the medical examination, recording results when appropriate, subject to verification of abnormal results by the physician:

- (1) Notes dictated by the physician.
- (2) Height and weight.
- (3) Visual acuity.

- (4) Color vision.
- (5) Auditory acuity (audiometry).
- (6) Electrocardiogram.
- (7) Blood pressure and pulse rate.
- (8) Drawing blood for serology.
- (9) Performing laboratory procedures.
- (10) Temperature.
- (11) X-rays.
- (12) Determining prescription of glasses by lensometer.
- (13) Prescribed physical exercises under the personal observation of the examining physician.

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 chapter 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 (Report of Medical Examination), SF 93 (Report of Medical History), and such other forms as may be required. See appendix IX and paragraph 10-15 for administrative procedures for filling out SF 88.

10-12. Remediable Medical Conditions and Physical Defects

When a medical examination reveals that an individual 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 paragraph 48, AR 600-20 and paragraph 3, AR 600-7. For US Army Reserve members see paragraph 4a, AR 140-120 and for ARNG see paragraph 9b, NGR 27.

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 paragraph 3-23c, AR 40-400 may be used.

c. Medical examiners will not routinely make recommendations for waivers of 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 DD Form 722 (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, Standard Form 88.

e. The scopes of Types A and B medical examinations and instructions for recording the examinations on Standard Form 88 are set forth 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.* Standard Form 93 (Report of Medical History) 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 ex-

(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 S.F.), 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 component 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 (chaps. 1, 3, and 8 in the case of medico-dental registrants). 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) General considerations.

(a) All Report of Periodic Medical Examinations will be reviewed by the commanding officer of the medical examining facility or by a physician designated by him.

(b) Standard Form 88 that indicates a member has a remediable defect which interferes with his ability to perform duty will be retained by the examining facility until definite arrangements for correction or followup are made with the individual or the unit commander. Upon completion of arrangements for hospitalization or indicated treatment, a comment to that effect will be entered in item 75 and the Report of Periodic Medical Examination will be forwarded to the unit commander for action as prescribed in (c) below. The unit commander will then forward these reports to the custodian of the individual's health record for filing therein.

★(c) When the SF 88 or DA Form 3349 (Medical Condition—Physical Profile Record) reflects a change in the individual's physical profile serial or assignment limitations, or both, appropriate entries will be made on DA Form

20 (Enlisted Qualification Record) or DA Form 66 (Officers Qualification Record). Reports of such changes will be made to Headquarters, Department of the Army, as required by pertinent personnel regulations.

(8) The medical examination for general officers and full colonels should be performed on an individual appointment basis. The duplicate report (Standard Form 88) in the case of each general officer and full colonel will be forwarded to The Adjutant General, ATTN: AGPF-O, Department of the Army, Washington, DC 20310, for file in the individual's DA Form 201.

(9) In addition to the periodic medical examination prescribed by c(2) below, all women in the Army on active duty, age 25 and over will undergo a breast and pelvic examination to include a Papanicolaou cancer detection test annually. This special examination 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 (DD Form 722).

b. Followup.

(1) A followup visit will be arranged for an individual on active duty whenever the periodic medical examination reveals that there are diagnostic tests which should be repeated or that additional tests should be conducted in order to complete the evaluation. Arrangements will be made for the treatment or correction of conditions or remedial defects affecting the continued satisfactory performance of military duty or adversely affecting the examinee's health and well-being.

(2) A Reservist who is not on active duty will be scheduled for followup appointments and consultations for the reasons stated in (1) above at Government expense when necessary to complete the examination. Treatment or correction of conditions or remediable defects discovered as a result of examination will be scheduled if authorized. If the individual is not authorized treatment, he will be advised to consult a private physician of his own choice at his own expense.

c. Frequency.

(1) An individual, whether or not on active duty, who is qualified under one of the classes for flying or as a marine diver will undergo a medical examination during the month in which his birthday anniversary occurs. In order to adjust an examination from the anniversary of the month in which the individual qualifies for flying or diving to his "birthday month," re-examination will be accomplished in the first "birthday month" after 3 but not more than 15 months following qualification. A similar one-time adjustment will be made in the periodic examinations of all individuals presently qualified for flying or marine diving.

★(2) Other military personnel on active duty are required to undergo a periodic medical examination during the anniversary months of their birthday ages as follows: 18, 21, 24, 27, 30, 32, 34, 36, 38, 40 and annually thereafter. As an exception to these requirements an individual who has had the initial medical examination at ages 17, 18, 19 or 20 for a 2-year period of active duty does not require an additional examination until the separation medical examination.

(3) All members of the Ready Reserve and ARNGUS not on active duty—

(a) At least once every 4 years during the anniversary month of the examinee's last recorded medical examination. Major Army commanders and the Chief, National Guard Bureau may, at their discretion, direct more frequent medical examinations in individual cases.

(b) Members of the Ready Reserve and ARNGUS not on active duty will accomplish a statement of medical fitness annually on reporting for AT. The statement used will be "Medical Statement No. 1" on the reverse of DD Form 220 (Active Duty Report).

(4) 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 de-

ferment will be made in the Health Record (DD Form 722) and on Health Record—Chronological Record of Medical Care (SF 600) when such a situation exists.

(5) 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 condition.

(1) Any change in physical profile or limitations found on periodic medical examination will be reported to the unit commander on DA Form 3349 (Medical Condition—Physical Profile Record) as prescribed in chapter 9.

(2) Retired personnel will be informed of the results of medical examination 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. Reserve component 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.

10-25. Separation Including Retirement

a. Except as noted below, all military personnel, including US Military Academy cadets, on active duty or active duty for training in excess of 30 days are required to undergo a medical examination prior to separation. The exception to this requirement applies to those individuals separated for the purpose of immediate enlistment or reenlistment. A separation medical examination is not required for these individuals. The following schedule of

separation medical examinations is established:

(1) Individuals on active duty or active duty for training for a period of 1 to 6 months will be examined not earlier than 30 days nor later than 15 days prior to the scheduled date of relief from active duty or active duty for training.

(2) Individuals on active duty, or active duty for training in excess of 6 months will be examined not earlier than 6 months nor later than 2 1/2 months prior to the scheduled date of termination of active duty status.

(3) Cadets separated from the US Military Academy prior to graduation will be examined prior to separation.

(4) Under exceptional circumstances, where conditions of the service preclude the accomplishment of the separation medical examination within the time prescribed, it may be deferred by direction of the commander having custody of the field personnel file until

such time as its accomplishment becomes feasible, but in no event later than 3 working days prior to departure from the place of transfer processing. Appropriate entries will be made in the Health Record when such a situation exists:

b. DA Form 3082-R (Statement of Medical Condition—When Examined More Than 3 Days Prior to Separation) will be reproduced locally on 8- by 10 1/2-inch paper in accordance with figure 10-2. The top margin will be approximately 3/4 inch to accommodate filing in Health Record. The form will be signed upon separation by those individuals required to undergo a separation medical examination and who undergo such examination more than 3 working days prior to date of departure from place of separation. If exceptions are noted, the member will be re-examined prior to separation. The statement will be attached to the separation Report of Medical Examination (SF 88) filed in the Health Record.

Section IV. FLYING DUTY MEDICAL EXAMINATIONS

10-26. Flying Duty

★*a. 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, 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.

b. *Definitions.* For the purpose of this sec-

tion the following terms will be employed with the meanings given:

(1) *Aerial flight.* Aerial flight is a journey in an aircraft. It begins when the aircraft takes off from rest at any point of support and terminates when it next comes to a complete stop at a point of support.

(2) *Designation.* The term designation is used to mean currently effective aeronautical appointment granted by the Chief of Staff, United States Army, or other properly designated authority. See AR 95-1 and AR 600-106.

(3) *Designated or rated personnel.* The term designated or rated personnel includes officers, warrant officers, and enlisted personnel who hold a currently effective aeronautical designation or rating.

(4) *Excusal.* When an individual on flying status is incapacitated for flying by reason of an aviation accident, he will not be required to perform aerial flights during such incapacity for a period not to exceed 3 months. He will not be suspended from flying status during this period, but will be excused from meeting

flight requirements and thereby will be eligible for flying pay. This action is termed excusal. If, following the 3-month period during which the individual is not required to perform aerial flights, he is not medically qualified for flying, action will be initiated recommending that he be suspended, either temporarily or indefinitely, from flying status.

(5) *Flying status.* Flying status is an official standing in which an individual has been ordered by proper authority to participate in regular and frequent aerial flights.

(6) *Rating.* The term rating means currently effective aeronautical ratings officially granted by the Chief of Staff, US Air Force, or other properly designated authority.

(7) *Serious illness or serious injury.* This term means any illness or injury that is adjudged by competent medical authority to have future 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 interfering with normal binocular visual function.

(8) *Suspension.* Suspension is withdrawal of an individual's authority to participate in regular and frequent aerial flights.

c. Disqualification.

(1) When a commander believes an individual 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 (*g* below). 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 their contents are of paramount importance.

(2) Personnel donating blood will not perform flying duty for a period of 72 hours following the donation. If he deems it necessary, the medical examiner may recommend suspension in accordance with AR 600-107.

(3) 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.

(4) A finding of qualification or disqualification for flying duty in any specific capacity will be made on the basis of the medical examination. Elaboration of this recommendation 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 nevertheless will be disqualified.

(5) 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 commanding officer of the examinee concerned in writing and in the most expeditious manner feasible. This officer will act on the basis of such notification. An individual will not be restored to flying status until he is again able to qualify medically or has received a waiver for his disqualifying defect granted by duly constituted authority. (See AR 600-107.)

d. Filing. Reports of medical examination for flying (including clinical medical summaries) will be put in the Individual Flight Record File as prescribed in AR 95-64. In addition, appropriate entries, such as prescriptions for glasses to be worn while flying, will be made in item 25, DA Form 759 (Individual Flight Record—Army Aviator).

e. Medical examination reports.

(1) Complete reports of medical examination for flying accomplished in conjunction with application for flight training pursuant to AR 611-85 and AR 611-110 will be forwarded directly to the commander having personnel jurisdiction over the applicant. In no case will completed reports of medical examination be

given to the applicant. Reports of medical examination for flying accomplished other than for flight training will be reviewed in accordance with paragraph 10-24 or AR 600-107, as appropriate; if forwarded to The Surgeon General for review, the reports will include one copy of Standard Form 93.

(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 Agency certification will be as prescribed by AR 40-2. A third copy of Standard Form 88 will be prepared if the individual desires a medical certificate from the Federal Aviation Agency.

★*f. Scope.* The prescribed Type B medical examination will be conducted in accordance with the scope specified in appendix IX.

g. Suspensions. Sick in hospital, sick in quarters, or sick leave status will be considered prima facie evidence of medical disqualification for flying duty. All suspensions are issued by written order. When suspension is for a minor illness or injury, not the result of an aviation accident, and is of a duration less than 30 days, it will be handled locally without reference to higher authority. Suspension of over 30 days and less than 6 months will be reported for confirmation to higher headquarters. Normally, this authority rests with a major command; however, it may be delegated to a subordinate command. Cases concerning suspensions for a serious illness or injury or suspensions which are expected to or do exist for greater than 6 months will be reported to Headquarters, Department of the Army for confirmation. Complete medical reports (including Standard Forms 88 and 93 and necessary consultations, if any) will accompany such cases. All suspensions of civilian flight instructors and test

pilots employed by the Department of the Army will be handled locally, whenever possible; however, the authority for confirmation of removal of suspension lies at the same level as that required for confirmation or the original suspension. See AR 600-107.

h. 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 a 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 when a medical question is involved.

(3) All personnel of the operating aircraft crew involved in an aircraft accident, if it appears that there is any possibility whatsoever that medical considerations may have been instrumental in causing, or should be investigated as a result of, such accident. An aviation medical examiner or other qualified medical officer will screen the crew members at the earliest practicable time to determine if a Type B medical examination is necessary.

i. Waivers.

(1) *General.* A separate request for waiver need not accompany a Report of Medical Examination. Recommendation concerning waivers will be made on the Report of Medical Examination. 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 letter-size paper. Waiver of minor defects will in no way compromise flying safety or affect the efficient performance of flying duty or the individual's well-being.

★(2) *Designated or rated personnel.* Designated or rated personnel who by reason of minor defects do not meet the requirements of this regulation may request a waiver from Chief of Personnel Operations, ATTN:

OPXAA, Department of the Army, Washington, DC 20315.

(3) *Initial applicants.* On the examination for flying training, rating, or designation, waivers will not be requested by an examinee or examination medical officer. However, if the examinee has a minor physical defect, a complete medical examination for flying will be accomplished and details of the defect recorded. The report will be attached to application for aviation training and forwarded as prescribed in the regulations applicable to the procurement program under which the application is submitted.

(4) *Nondesignated or nonrated personnel.* In nondesignated or nonrated personnel, minor physical defects which will in no way affect the efficient performance of flying duties will be waived by the commander of the unit or station upon recommendation of a qualified medical officer. Notification of such disqualification will be forwarded, in all instances in writing, by the hospital commander or the medical officer concerned to the disqualified individual's commanding officer with appropriate recommendations for suspension from flying status in accordance with existing directives. See AR 600-107.

j. Review and waiver action. The comman-

der of a major command, the Commandant of the Army Aviation School and the Commanding Officer, US Army Primary Helicopter Center, are authorized to make final determination of the medical qualifications for continuance on flying status of aviation personnel permanently assigned to duty in their commands. This same authority is delegated to the Chief, National Guard Bureau, for members of the National Guard not on active duty and includes authority to—

(1) Grant administrative waivers for physical defects and medical conditions which unquestionably do not compromise the individual's health or flying safety, but not below the medical fitness standards (exclusive of para 3-3) contained in chapter 3.

(2) Impose intermediate suspension (AR 600-106 and AR 600-107).

(3) Make final certification as to the medical qualification for flying or aviation officers:

(a) Who are under consideration for—

1. Intermediate suspension,
2. Revocation of intermediate suspension, or

3. Recession of such suspension.

(b) Who are permanently assigned to duty within the jurisdiction of that command, school, or chief.

Section V. USMA MEDICAL EXAMINATIONS

10-27. US Military Academy

a. General. This section sets forth administrative procedures applicable to medical examinations of candidates and prospective candidates for the US Military Academy, other service academies, and the respective preparatory schools (chap. 5).

★*b. Distribution of medical reports.* Upon completion all medical reports (the originals only of SF 88, SF 93 and supplemental reports) to include X-rays of abnormalities, photographs and dental casts, will be forwarded as follows:

(1) United States Military Academy: The Surgeon General, ATTN: MEDPS-SP, Department of the Army, Washington, DC 20314. The Adjutant General will transmit copies of all

such reports to the Superintendent, United States Military Academy, West Point, NY 10996, and make other required distribution.

(2) United States Naval Academy: Superintendent, United States Naval Academy, Annapolis, MD. 21402.

(3) United States Air Force Academy: Superintendent, United States Air Force Academy, Colorado Springs, CO 80840.

(4) If the examinee indicates he is an applicant for more than one service academy, the originals of all medical reports will be forwarded to the service indicated as his first choice. Duplicates suitable for copying will be forwarded to the other specified service(s) as appropriate and as noted above.

c. Facilities and authorization for examina-

tion. Qualifying medical examination (Type B) of applicants or nominees for admission to Service academies are accomplished at medical facilities designated for this purpose and listed in the current catalogs of the academies. Individuals will be examined on presentation of a signed written request from one of the following:

(1) Congressional: The Member of Congress concerned.

(2) Competitive: The Adjutant General, Department of the Army; the Chief of Naval Personnel, Navy Department; or the Director of Admissions, US Air Force Academy.

(3) Sons of Persons Awarded the Medal of Honor: Same as (2) above.

d. Preparatory school. A member of the Army being considered for attendance at the US Military Academy Preparatory School is not required to undergo medical examination specifically to qualify for selection. A medical officer will review his Health Record and most recent Report of Medical Examination and, using the medical fitness standards of chapter 5, will arrive at a conclusion as to the probability of the applicant meeting medical fitness requirements for admission to the Academy. The reviewing medical officer may direct the accomplishment of any necessary tests or procedures that he feels necessary to resolve any questionable area(s) of medical fitness. The results will be entered in item 73 of the individual's most recent Report of Medical Examination which will be forwarded with his application. Tests or further examination will be limited to those instances where the physician's review of the record indicates that the applicant may not be medically qualified for entrance into the US Military Academy. A Type B medical examination will eventually be conducted at the Preparatory School.

c. Release of examination results. Examinees may be advised as to existence of remediable medical or dental defects, but no commitment is to be made as to qualification or disqualification of any examinee regardless of circumstances. Copies of Report of Medical Examination will not be furnished examinees or sponsors. Requests, oral or written, for medical

information concerning Air Force or Naval Academy examinees will be referred to the appropriate academy superintendent. Requests pertaining to USMA examinees will be referred to The Adjutant General, ATTN: AGPB-M, Department of the Army, Washington, DC 20315.

f. Scope. Qualifying medical examinations for the US Military Academy, the US Naval Academy and the US Air Force Academy will be of the scope prescribed for Type B examinations.

g. Standard Form 88 (Report of Medical Examination).

(1) *Additional information.* The following information will be included on all copies of reports of qualifying medical examination in addition to that required by paragraph 10-14 and appendix IX.

(a) An entry in item 5 such as "USMA", "USNA" and/or "USAFA".

(b) The name of the person requesting the examination and, if applicable, his title or position, in item 16.

(c) An appropriate note will be entered identifying X-ray films and any photographs of dental casts transmitted with the form.

(d) Item 77 as to whether the applicant or nominee is qualified or disqualified for the United States Military Academy or the United States Naval Academy, as applicable, may be completed as a recommendation of the examining physician. In the case of a United States Air Force Academy applicant or nominee, no entry will be made in item 77.

(e) The report of medical examination will be signed by at least one medical examiner and one dental examiner.

(2) *Dental examination.* The following procedures apply to all dental examinations conducted in connection with US Military Academy qualification.

(a) Notation will be made concerning the serviceability of dentures or bridges.

(b) Defects, infections, and periodontal disease, described as to severity, will be listed.

(c) An examinee wearing appliances for active orthodontic treatment will be re-

requested to obtain from his attending orthodontist a written statement indicating the expected date by which the orthodontic appliances may be removed or replaced by retainer type appliances.

(d) Casts of the upper and lower arches will be made only when the conditions listed in paragraphs 5-5b, c(2), and d(2) are found. At least three pencil marks will be drawn across both casts to indicate the closed position, and the examinee's name will be placed on each cast. When a cast is required of an arch supporting a removable prosthesis the impression will be made with the appliance in place whenever practicable. No cast is required of an edentulous arch which supports no prosthetic appliance unless the relationship between the mandible and maxilla precludes future satisfactory prosthetic replacements, in which case articulator mounting is indicated. In such cases the condition will be fully described in item 44 and/or items 73 and 74.

★h. *DA Form 3742 (Personal History Questionnaire—Medical Examination—US Armed Forces Service Academies).*

(1) All applicants and candidates for admission to the United States Military Academy, United States Naval Academy, and the United States Air Force Academy as a part of their medical examination, are required to complete one copy of DA Form 3742.

(2) The DA Form 3742, when completed by the examinee, will be used by the examiners

who conduct the psychiatric phase of the medical examination. The Questionnaire will be carefully reviewed by the examiner, and elaborated upon in the space provided for the interviewer's comments. A rating of "satisfactory" or "unsatisfactory" will be recorded in the space provided. Such rating will reflect the examiner's comments.

(3) The examinee will not be disqualified solely on the basis of information contained in the DA Form 3742. Any psychiatric problem elicited by the examiner, as a result of review of the Questionnaire and personal interview with the examinee, must be confirmed by clinical evaluation, and a diagnosis definitely established.

(4) The DA Form 3742, when completed by the examinee and examiner, becomes a part of the Report of Medical Examination, and will be attached to the original Standard Form 88 to be forwarded to appropriate reviewing officials.

★i. *Standard Form 93 (Report of Medical History).* A complete and accurate medical history must be compiled with particular care. The applicant or nominee will provide full explanation of all diseases, including those of a familial nature, injuries and operations affecting his medical status. The examining physician will thoroughly investigate all questionable areas, carefully evaluate the report, and summarize all pertinent data under item 40.

j. *Waivers.* See paragraphs 1-4, 7-14, and 10-14c.

Section VI. MOBILIZATION MEDICAL EXAMINATIONS

10-28. Mobilization Medical Examinations
For administrative procedures applicable to

mobilization 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 spe-

cialties 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 regula-

tion, AR 40-5, TB MED 251, TB MED 270, TB MED 279 and AR 611-201.

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 attachés, military missions, military assistance advisory groups, or in isolated areas, the commander of the station to which he is assigned will refer the individual and his 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 7-9 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 Health Data Publications of the Walter Reed Army Institute of Research 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 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 review of available medical records, discussion with the individual and his dependents, and findings of the medical examination, if accomplished, the physician finds them medically qualified in every respect under paragraph 7-9d, and to meet the conditions which will be encountered in the area of contemplated assignment, he will complete and sign DA Form 3083-R (Medical Examination for Certain Geographical Areas). This form will be reproduced locally on 8- by 10½-inch paper in accordance with figure 10-3. The top margin of form to be approximately ¾ inch for filing in Health Record and Outpatient Record. A copy of this statement will be filed in the Health Record (AR 40-403) or Outpatient Record (AR 40-425) and a copy forwarded to 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 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 parent 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 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 8-118 (Medical Board Proceedings) or DA Form 3349 (Medical Condition—Physical Profile

Record) may be used, the selection depending on the eventual use of the report.

(4) Periodic medical examinations and medical examinations conducted for the purpose of separation and immediate reenlistment may be waived by the commanding officer 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 at a military installation having a medical facility. Medical examination of such individuals for separation or retirement purposes may not be waived.

Section VIII. MEDICO-DENTAL REGISTRANTS

MEDICAL EXAMINATIONS

10-30. Medico-Dental Registrants Medical Examinations

Administrative procedures applicable to medi-

cal and dental registrants under the Universal Military Training and Service Act, as amended, are set forth in AR 601-270. Also see chapter 8.

PERIODIC MEDICAL EXAMINATION (Statement of Exemption) (AR 40-501)	DATE
LAST NAME - FIRST NAME - MIDDLE INITIAL, GRADE & SERVICE NO. (Type or Print)	
ORGANIZATION	
<p style="text-align: center;"> I underwent a medical examination in conjunction with _____ on or about _____ at _____ (Date) (Medical Treatment Facility) </p> <p> and to the best of my knowledge there has been no significant change in my medical condition since the accomplishment of this medical examination. </p> <p style="text-align: center;"> _____ (Signature) </p>	

DA Form 3081-R, 1 Feb 66

Figure 10-1.

MEDICAL EXAMINATION FOR CERTAIN GEOGRAPHICAL AREAS (AR 40-501)		DATE
MILITARY MEMBER'S LAST NAME-FIRST NAME-MIDDLE INITIAL, GRADE & SERVICE NO. (Type or Print)		
ORGANIZATION		COUNTRY ASSIGNED
DEPENDENTS		
NAME	RELATIONSHIP	AGE
Based upon a review of available medical records and the results of examination as necessary the following recommendations are submitted: <input type="checkbox"/> Service member is medically qualified to undertake proposed assignment. <input type="checkbox"/> Service member is not medically qualified to undertake proposed assignment. <input type="checkbox"/> Dependents listed above <input type="checkbox"/> are <input type="checkbox"/> are not medically qualified to accompany service member. REMARKS:		
(Continus on reverse side if necessary)		
MEDICAL TREATMENT FACILITY		
TYPED OR PRINTED NAME OF EXAMINING PHYSICIAN		SIGNATURE OF EXAMINING PHYSICIAN

DA Form 3083-R, 1 Feb 66

Figure 10-3.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
45 A B C D	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	★Identify tests used and record results. Items A and D not routinely required for type "A" medical examinations accomplished for initial entrance, or for routine separation. Must be accomplished for all Type B examinations and for periodic or retirement examinations.	
46	✓	✓	Note film size, number, date and place taken and findings. A report of chest X-ray accomplished within the preceding 12 months may, at the discretion of the examining physician, be accepted in lieu of a current chest X-ray. Note facility, place and date taken, film size, number, wet or dry reading and findings. Reading must be by radiologist, or internist experienced in radiology.	14 x 17 film No. 54321 Letterman General Hospital, San Francisco, Calif., 8 December 1964, dry reading, negative.
47	✓	✓	Kahn, Wasserman, VDRL, or cardiolipin microflocculation tests recorded as negative or positive. On positive reports note date, place and titre, Serology not required for periodic examination.	Cardiolipin. Microflocculation. Negative. Normal. Abnormal—see attached report.
48	(*)	✓	*Required for retirement or if age 40 or over; also if indicated. Representative samples of all leads (including precordial leads) properly mounted and identified on Standard Form 520 (EKG report) will be attached to the original of SF 88. Standard Form 520 should be attached to all copies of SF 88. The interpretation of the EKG will be entered in item 48 (or 73 if necessary) on all copies of SF 88.	Normal. Abnormal—see attached report.
49			★(Rescinded)	
50	(*)	(*)	*Only if indicated. Identify test(s) and record results.	
51	✓	✓	Record in inches to the nearest quarter inch (without shoes).	71½.
52	✓	✓	Record in pounds to the nearest whole pound (without clothing and shoes).	164.
53	✓	✓	Record as black, blond, brown, gray or red.	Brown.
54	✓	✓	Record as blue, brown, gray or green.	Blue.
55	✓	✓	Enter X in appropriate space. If obese, enter X in two spaces as appropriate. For definition of obesity see appendix I.	
56	(*)	✓	*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6°.
57 A, B and C	(*)	✓	Record sitting blood pressure for all examinations. *Only if indicated by abnormal findings in A, i.e., if sitting blood pressure is 140/90 or more for individuals below age 35, or 150/90 for those age 35 and above. Any abnormal reading should be rechecked by recording blood pressure readings twice a day (morning and afternoon) for 3 consecutive days.	110/76.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
58 A	✓	✓	Record for all examinees.	
B, C, D and E	(*)	✓	*Record only if indicated by abnormal findings in 58A, i.e., if A is 100 or more, or below 50. If either D or E is 100 or more, or less than 50, record pulse twice a day (morning and afternoon) for 3 days and enter in item 73. Also record average pulse in item 73.	
59	✓	✓	Record in terms of the English Snellen Linear System (20/20, 20/30, etc.) of the uncorrected vision of each eye. If uncorrected vision of either eye is less than 20/20, entry will be made of the corrected vision of each eye.	20/100 corr. to 20/20. 20/50 corr. to 20/20.
60	(*)	✓	*Refraction required for induction enlistment and appointment if <i>corrected</i> vision is less than the minimum visual standards stated in paragraph 2-13a, or if deemed appropriate by the examiner regardless of visual acuity. Cycloplegic required for initial selection for service academies and preparatory schools, diving and Class I, IA flying duty thereafter only if determined desirable by the examiner. The word "manifest" or "cycloplegic," whichever is applicable, will be entered after "refraction." An emmetropic eye will be indicated by plano or 0. For corrective lens, record refractive value.	By - 1.50 S + 0.25 CX 05. By - 1.50 S + 0.25 CX 175.
61	✓	✓	Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20) or entry will be made of the corrected vision for each eye and lens value after the word "by."	20/40 corr. to 20/20 by same. 20/40 corr. to 20/20 by +0.50.
62	—	✓	Identify the test used, i.e., either the Maddox Rod Test or the Armed Forces Vision Tester, and record results. Prism Div and PD not required. Not required for dependents.	Armed Forces Vision Tester. ES° 4 EX° 0 R.H. 0 L.H. 0 Prism Div.CT Ortho PC 35 PD
63	—	✓	Record values without using the word "diopters" or symbols.	Right 10.0 Left 9.5.
64	✓	✓	Required only as initial test and subsequently only when indicated. Not required for dependents. Record results in terms of the test used, pass or fail, and number of plates missed over the number of plates in the test. If examinee fails Pseudoisochromatic Test, he will be tested for red/green color vision and results recorded as "passed" or "failed red/green."	Pseudoisochromatic Plate Set Fail 6/17 Passed red/green.
65	—	✓	Identify test used and record results for corrected and uncorrected. Enter dash in corrected space if applicable. Score is entered for Howard-Dolman; passes or fails is used for Verhoeff.	Howard-Dolman 25. Verhoeff passes.

S/S C28 June 14, 1972

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

★7-9. 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 d below.

★c. Rescinded.

d. MAAG's, military attachés, military missions and duty in isolated areas (see AR 55-46, AR 600-200, and AR 612-35).

(1) The following medical conditions and defects will preclude assignment or attachment to duty with MAAG's, military attachés, military missions, or any type duty in isolated oversea stations requiring residence in areas where U.S. military treatment facilities are limited or non-existent:

- (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 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 from CONUS.
- (4) Findings and recommendations of the examining physicians and dentists will be based entirely on the examination and a review of the Health Record, outpatient, or inpatient medical records. Motivation of the examinee

must be minimized and recommendations based only on the professional judgment of the examiners.

e. The medical fitness standards set forth in d above are prescribed for the purpose of meeting selection criteria for military personnel

under consideration for assignment or attachment to duty with MAAG's, military attachés, military missions or any type duty in isolated oversea stations. These fitness standards also pertain to dependents of personnel being considered.

Section VII. MEDICAL FITNESS STANDARDS FOR ADMISSION TO SERVICE ACADEMIES OTHER THAN U.S. MILITARY ACADEMY

7-10. Medical Fitness Standards for Admission to U.S. 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, U.S. Navy as well as NAVPERS 15,010 Regulations Governing the Admission of Candidates into the United States Naval Academy as Midshipmen.

7-11. Medical Fitness Standards for Admission to U.S. 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.

Section VIII. SPECIAL ADMINISTRATIVE CRITERIA APPLICABLE TO CERTAIN MEDICAL FITNESS REQUIREMENTS

The special administrative criteria in paragraphs 7-12 through 7-15 are listed for the information and guidance of all concerned.

★7-12. Dental—Induction and Appointment or Enlistment in U.S. Army (See para 2-5.)

a. Individuals with orthodontic appliances attached are administratively unacceptable for the following as long as active treatment is required:

(1) Appointment as a commissioned or warrant officer in any component (except for physicians, dentists and other specialists liable for military service under the Military Selective Service Act of 1967 who will be evaluated under standards prescribed for those procurement programs).

(2) Enlistment or induction of personnel in any component of the U.S. Army.

(3) Reenlistment of personnel in any component of the U.S. Army after more than 90 days from date of separation.

b. Applicants for appointment to the United States Military Academy, and the several programs of the Army ROTC are acceptable with orthodontic appliances.

c. Officers and enlisted personnel of all components are acceptable for active duty, or active duty for training under the Reserve Enlistment Program of 1963, if the orthodontic appliances were affixed 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 with retainer orthodontic appliances who are not required to undergo active treatment are administratively acceptable for appointment, enlistment or induction.

7-13. Height—Regular Army Commission (See para 2-21a (1).)

The following applies to all males being considered for a Regular Army commission:

a. Individuals being considered for appointment in the Regular Army in other than Armor, Artillery, or Infantry who are not more than 2 inches below the minimum height requirement of 66 inches *will automatically* be

15027 Aug 10, 1971

Section IV. DENTAL

2-5. Dental

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

a. *Diseases of the jaws or associated tissues* which are not easily remediable and 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 7-12.

e. Relationship between the mandible and maxilla of such a nature as to preclude future satisfactory prosthodontic replacement.

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*: Agenesis, severe; or severe traumatic deformity, unilateral or bilateral.

c. *Mastoids*:

(1) Mastoiditis, acute or chronic.

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

(3) Mastoid fistula.

d. *Meniere's syndrome*.

e. *Middle ear*:

(1) Acute or chronic suppurative otitis media. Individuals with a recent history of acute suppurative otitis media will not be accepted unless the condition is healed and a sufficient interval of time subsequent to treatment has elapsed to insure that the disease is in fact not chronic.

(2) Adhesive otitis media associated with hearing level by audiometric test of 20 db or more average for the speech frequencies (500, 1000, and 2000 cycles per second) 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).

f. *Tympanic membrane*:

★(1) Any perforation of the tympanic membrane.

(2) Severe scarring of the tympanic membrane associated with hearing level by audiometric test of 20 db or more average for the speech frequencies (500, 1000, and 2000 cycles per second) 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—

Hearing acuity level by audiometric testing (regardless of conversational or whispered voice hearing acuity) greater than that described in table I, appendix II. There is no objection to conducting the whispered voice test or the spoken voice test as a preliminary to conducting the audiometric hearing test.

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Step 105

Section VI. ENDOCRINE AND METABOLIC DISORDERS

★2-8. Endocrine and Metabolic Disorders

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

- a. *Adrenal gland*, malfunction of, of any degree.
- b. *Cretinism*.
- c. *Diabetes insipidus*.
- d. *Diabetes mellitus*.
- e. *Gigantism or acromegaly*.
- f. *Glycosuria*, persistent, regardless of cause.
- g. *Goiter*:
 - (1) Simple goiter with definite pressure symptoms or so large in size as to interfere with the wearing of a military uniform or military equipment.
 - (2) *Thyrotoxicosis*.
- h. *Gout*.

- i. *Hyperinsulinism*, confirmed, symptomatic.
- j. *Hyperparathyroidism* and *hypoparathyroidism*.
- k. *Hypopituitarism*, severe.
- l. *Myxedema*, spontaneous or postoperative (with clinical manifestations and not based solely on low basal metabolic rate).
- m. *Nutritional deficiency diseases* (including sprue, beriberi, pellagra, and scurvy) which are more than mild and not readily remediable or in which permanent pathological changes have been established.
- n. *Other endocrine or metabolic disorders* which obviously preclude satisfactory performance of duty or which require frequent and prolonged treatment.

Section VII. EXTREMITIES

2-9. Upper Extremities

(See 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 (app. IV).

- (1) *Shoulder*:
 - (a) Forward elevation to 90°.
 - (b) Abduction to 90°.
- (2) *Elbow*:
 - (a) Flexion to 100°.
 - (b) Extension to 15°.
- (3) *Wrist*: A total range of 15° (extension plus flexion).
- (4) *Hand*: Pronation to the first quarter of the normal arc.
Supination to the first quarter of the normal arc.
- (5) *Fingers*: Inability to clench fist, pick up a pin or needle, and grasp an object.

b. *Hand and fingers*:

- (1) Absence (or loss) of more than $\frac{1}{3}$ 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 irrespective of the absence (or loss) of little finger.

- (2.1) Absence of more than the distal phalanx of any two of the following fingers, index, middle finger or ring finger, of either hand.
- (3) Absence of hand or any portion thereof except for fingers as noted above.
- (4) Hyperdactylia.
- (5) Scars and deformities of the fingers and/or hand which impair circulation, are symptomatic, are so disfiguring as to make the individual objectionable in ordinary social relationships, or which impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

c. *Wrist, forearm, elbow, arm, and shoulder*: Healed disease or injury of wrist, elbow, or shoulder with residual weakness or symptoms of such a degree as to preclude satisfactory performance of duty.

2-10. Lower Extremities

(See 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 (app IV).

(1) *Hip.*

- (a) Flexion to 90°.
- (b) Extension to 10° (beyond 0).

(2) *Knee.*

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

(3) *Ankle.*

- (a) Dorsiflexion to 10°.
- (b) Plantar flexion to 10°.

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

c. b. Foot and ankle.

- (1) Absence of one or more small toes of one or both feet, if function of the foot is poor or running or jumping is precluded, or absence of foot or any portion thereof except for toes as noted herein.
- (2) Absence (or loss) of great toe(s) or loss of dorsal flexion thereof if function of the foot is impaired.
- (3) Claw toes precluding the wearing of combat service boots.
- (4) Clubfoot.
- (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, spastic.
- (7) Hallux valgus, if severe and associated with marked exostosis or bunion.
- (8) Hammer toe which interferes with the wearing of combat service boots.
- (9) Healed disease, injury, or deformity including hyperdactylia which precludes running, is accompanied by disabling pain, or which prohibits wearing of combat service boots.
- (10) Ingrowing toe nails, if severe, and not remediable.
- (11) Obliteration of the transverse arch associated with permanent flexion of the small toes.
- (12) Pes cavus, with contracted plantar fascia, dorsiflexed toes, tenderness un-

der 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, or history of surgical correction of same if—

- (a) Within the preceding 6 months.
- (b) Six months or more have elapsed since operation without recurrence, and there is instability of the knee ligaments in lateral or anteroposterior directions in comparison with the normal knee or abnormalities noted on X-ray, there is significant atrophy or weakness of the thigh musculature in comparison with the normal side, there is not acceptable active motion in flexion and extension, or there are other symptoms of internal derangement.

- (2) Authentic history or physical findings of an unstable or internally deranged joint causing disabling pain or seriously limiting function. Individuals with verified episodes of buckling or locking of the knee who have not undergone satisfactory surgical correction or if, subsequent to surgery, there is evidence of more than mild instability of the knee ligaments in lateral and anteroposterior directions in comparison with the normal knee, weakness or atrophy of the thigh musculature in comparison with the normal side, or if the individual requires medical treatment of sufficient frequency to interfere with the performance of military duty.

d. General.

- (1) Deformities of one or both lower extremities which have interfered with function to such a degree as to prevent the individual from following a *physically active* vocation in civilian life or which 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 which interfere with walking, running, or weight bearing.

- (3) Pain in the lower back or leg which is intractable and disabling to the degree of interfering with walking, running, and weight bearing.
- (4) Shortening of a lower extremity resulting in any limp of noticeable degree.

2-11. Miscellaneous

(See also para 2-9 and 2-10.)

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

a. Arthritis.

- (1) Active or subacute arthritis, including Marie-Strumpell type.
- (2) Chronic osteoarthritis or traumatic arthritis of isolated joints of more than 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.
- (4) Traumatic arthritis of a major joint of more than minimal degree.

b. *Disease of any bone or joint*, healed, with such resulting deformity or rigidity that function is impaired to such a degree that it will interfere with military service.

c. *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 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.

d. 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 were used for fixation and left in place and which may be subject to easy trauma, i.e., as a plate tibia, etc.

e. *Injury of a bone or joint* within the preceding 6 weeks, without fracture or dislocation, of more than a minor nature.

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

f.1 *Myotonia congenita*. Confirmed.

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

h. Osteoporosis.

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

★j. *Chondromalacia*, manifested by verified history of joint effusion, interference with function, or residuals from surgery.

Section VIII. EYES AND VISION

2-12. Eyes

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

a. Lids.

- (1) Blepharitis, chronic more than mild. 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) Disfiguring cicatrices and adhesions of the eyelids to each other or to the eyeball.

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- (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 paragraphs 2-40 and 2-41.
 - (7) Marked inversion or eversion of the eyelids sufficient to cause unsightly appearance or 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. Individuals with acute conjunctivitis are unacceptable until the condition is cured.
- (2) Pterygium:
 - (a) Pterygium recurring after three operative procedures.
 - (b) Pterygium encroaching on the cornea in excess of 3 millimeters or interfering with vision.

c. Cornea.

- (1) Dystrophy, corneal, of any type including keratoconus of any degree.
- (2) Keratitis, acute or chronic.
- (3) Ulcer, corneal; history of recurrent ulcers or corneal abrasions (including herpetic ulcers).
- (4) Vascularization or opacification of the cornea from any cause which interferes with visual function or is progressive.

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 function.
- (2) Degenerations of the retina to include macular cysts, holes, and other degenerations (hereditary or acquired degenerative changes) and other conditions affecting the macula. All types

of pigmentary degenerations (primary and secondary).

- (3) Detachment of the retina or history of surgery for same.
- (4) Inflammation of the retina (retinitis or other inflammatory conditions of the retina to include Coat's disease, diabetic retinopathy, Eales' disease, and retinitis proliferans).

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 document history of attacks of retrobulbar neuritis.
- (3) Optic atrophy (primary or secondary).
- (4) Papilledema.

g. Lens.

- (1) Aphakia (unilateral or bilateral).
- (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 interfering with visual function (i.e., may suppress).
- (2) Diplopia, monocular, documented, interfering with visual function.
- (3) Nystagmus, with both eyes fixing, congenital or acquired.
- (4) Strabismus of 40 prism diopters or more, uncorrectable by lenses to less than 40 diopters.
- (5) Strabismus of any degree accompanied by documented diplopia.
- (6) Strabismus, surgery for the correction of, within the preceding 6 months.

i. Miscellaneous defects and diseases.

- (1) Abnormal conditions of the eye or vis-

"R" or "T" will undergo appropriate medical evaluation to determine the desirability of termination of the modifier. In those instances where the termination of the modifier is not deemed appropriate, the procedure in AR 635-200 will be followed in the case of enlisted personnel and AR 635-100 in the case of officer personnel.

b. Individuals whose period of service expires and whose physical profile code is "W" will appear before a medical board to determine if processing as provided in paragraphs 3-3 and 3-4 is indicated.

c. Individuals whose period of service expires and whose physical profile code is "V" will appear before a medical board for processing as provided in paragraph 3-4.

9-10. Assignment Restrictions, or Geographical or Climatic Area Limitations

Paragraph 7-9 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 (Medical Condition—Physical Profile Record). 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 no assignment limitations associated with a numerical designator "2" except that an individual with a "2" does not meet the medical fitness standards for Ranger training or initial assignment to Airborne and Special Forces.

c. There are significant assignment restrictions, or geographical or climatic area limita-

tions associated with a physical profile identified with one or more numerical designator "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 designator "4" when the individual is on active duty.

e. Permanent assignment limitations under peacetime conditions (AR 40-3) normally will be established only by a medical board. Individuals accepted for military service under the provisions of chapter 8 will have assignment limitations established by the AFEES profiling officer.

f. Permanent geographical or climatic area assignment limitations may be removed or modified only by a medical board.

g. In every instance each medical condition or physical defect causing an assignment limitation will be identified in nontechnical language.

h. 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 his family. Individuals found fit for military service must be utilized in positions wherein the maximum benefit can be derived from their capabilities. It is desirable that all limitations be confirmed at least once every 3 years, particularly in conjunction with the periodic medical examination, with a view to updating the nature and extent of limitations.

9-11. Responsibility for Personnel Actions

Unit commanders are responsible for necessary personnel actions, including appropriate entries on personnel management records and the assignment of the individual to military duties commensurate with his physical profile and recorded assignment limitations.

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MEDICAL CONDITION - PHYSICAL PROFILE RECORD							DATE	
For use of this form, see AR 40-501; the proponent agency is The Surgeon General's Office.							1 April 1968	
TO: (Include Zip Code) Commanding Officer Co B, 555 Engr-Constr Bn APO 58 %Postmaster, New York, New York				FROM: (Include Zip Code) Commanding Officer 34th General Hospital APO 58 % Postmaster, New York, New York				
LAST NAME - FIRST NAME - MIDDLE INITIAL, GRADE, SERVICE NO./SOCIAL SECURITY ACCOUNT NUMBER AND ORGANIZATION Smith, Harold F. S/sgt 31033693 Co B, 555 ECB APO 58 % Postmaster, New York, N. Y.				INSTRUCTIONS Complete Section D of this form in lieu of DA Form 8-118, whenever a medical board is held for the sole purpose of permanently revising the physical profile to or from a numerical designator "3". PREPARE COPIES AS INDICATED BELOW: Unit Commander - 1 copy when Item 1 or 2 is checked Appropriate Commander or HQ - 1 copy when Item 3 is checked. Health Record Jacket, (DD Form 722) - 1 copy Clinical Record - 1 copy when appropriate				
SECTION A - DUTY STATUS (Check Applicable Item(s))								
1	<input checked="" type="checkbox"/>	INDIVIDUAL IS RETURNED TO YOUR UNIT FOR DUTY (AR 40-3, AR 635-40)						
2	<input type="checkbox"/>	INDIVIDUAL IS RETURNED TO YOUR UNIT FOR SEPARATION PROCESSING (AR 40-3, AR 635-40)						
3	<input checked="" type="checkbox"/>	INDIVIDUAL (IS) (IS NOT) MEDICALLY QUALIFIED FOR <i>duty with permanent assignment</i> AS EVIDENCED BY A MEDICAL EXAMINATION AND A REVIEW OF HIS HEALTH RECORD THIS DATE <i>limitation</i>						
SECTION B - PHYSICAL PROFILE								
(Complete all items. When applicable "R" or "T" will be entered with numerical designator under appropriate factor)								
4	PREVIOUS	P	U	L	H	E	S	PREVIOUS
		/	/	/	/	/	/	
5	PRESENT	3	/	/	/	/	/	PRESENT
6 (INDIVIDUAL HAS THE DEFECT(S) LISTED BELOW. (All defects requiring a 3 or 4 in any PULHES factor will be reported in non-technical language) <div style="font-size: 2em; font-family: cursive; margin-left: 50px;">Stomach ulcer</div>								
<input type="checkbox"/> Continued under remarks								
SECTION C - ASSIGNMENT RESTRICTIONS, OR GEOGRAPHICAL, OR CLIMATIC AREA LIMITATIONS (Check Applicable Item(s))								
7	<input type="checkbox"/>	INDIVIDUAL REQUIRES NO MAJOR ASSIGNMENT, GEOGRAPHICAL, OR CLIMATIC AREA LIMITATIONS						
8	<input type="checkbox"/>	MAJOR ASSIGNMENT, GEOGRAPHICAL, OR CLIMATIC AREA LIMITATIONS ARE ESTABLISHED BELOW (AR 40-3, AR 40-501, AR 635-40. Describe specific assignment limitations or restrictions as outlined in Chapter 9, AR 40-501.)						
No assignment to units requiring continued consumption of combat rations								
<input type="checkbox"/> Continued under remarks								
9	<input checked="" type="checkbox"/>	THE ABOVE CONDITIONS ARE PERMANENT						
10	<input type="checkbox"/>	THE ABOVE CONDITIONS ARE TEMPORARY, INDIVIDUAL IS TO REPORT TO A MEDICAL FACILITY ON (Date) FOR FURTHER PHYSICAL PROFILE EVALUATION OR MEDICAL TREATMENT AND DISPOSITION (AR 40-3, AR 40-501)						
11	<input type="checkbox"/>	SEPARATION OR RETIREMENT OF THIS INDIVIDUAL WILL NOT BE EFFECTED WITHOUT PRIOR MEDICAL EVALUATION (AR 40-3, AR 40-501, AR 635-40)						
12	<input checked="" type="checkbox"/>	THIS SUPERSEDES PREVIOUS MEDICAL CONDITION - PHYSICAL PROFILE RECORDS						
13. TYPED NAME & GRADE OF AUTHORIZED OFFICER AT MEDICAL FACILITY								
SIGNATURE								

DA FORM 3349
1 MAY 68

REPLACES DA FORM 8-274, 1 MAY 65, WHICH MAY BE USED UNTIL EXHAUSTED.

SECTION D - MEDICAL BOARD PROCEEDINGS		
ACTION BY MEDICAL BOARD		
PERMANENT CHANGE OF PROFILE AS RECORDED UNDER SECTION C, IS RECOMMENDED:		
14. TYPED NAME, GRADE & BRANCH OF BOARD MEMBER (President)	SIGNATURE	
JAMES H. HANSON LT COL MC		
15. TYPED NAME, GRADE & BRANCH OF BOARD MEMBER	SIGNATURE	
LOUIS T. ALPER CAPT MC		
16. TYPED NAME, GRADE & BRANCH OF BOARD MEMBER	SIGNATURE	
REED LARSON CAPT MC		
ACTION BY APPROVING AUTHORITY		
THE FINDINGS AND RECOMMENDATIONS OF THE BOARD ARE APPROVED:		
17. TYPED NAME, GRADE & TITLE OF APPROVING AUTHORITY	SIGNATURE	DATE
WILLIAM B. STRYKER COL MC		1 Apr 68
REMARKS - CONTINUATION OF ITEM ()		
Assignment Restrictions, or Geographical, or Climatic Area Limitations		
CODE: A - None B - None C - No crawling, stooping, running, jumping, prolonged standing or marching. D - No strenuous physical activity. E - No assignment to units requiring continued consumption of combat rations. F - No assignment to isolated areas where definitive medical care is not available. (MAAG - Military Missions, etc.). G - No assignment requiring prolonged handling of heavy materials including weapons. No overhead work, no pull-ups or push-ups. H - No assignment to unit where sudden loss of consciousness would be dangerous to self or others, such as work on scaffolding, handling ammunition, vehicle driving, work near moving machinery. J - No assignment involving habitual or frequent exposure to loud noises or firing of weapons. (Not to include firing for POR qualification.) L - No assignment which requires prolonged or repeated exposure to extreme cold. M - No assignment requiring prolonged or repeated exposure to high environmental temperature. N - No continuous wearing of combat type boots. P - No continuous wearing of woolen clothes. U - Limitation not otherwise described; to be considered individually. Briefly define limitation in Item 8.		

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★CHAPTER 10

MEDICAL EXAMINATIONS—ADMINISTRATIVE PROCEDURES

Section I. GENERAL PROVISIONS

10-1. Scope

a. This chapter provides general administrative policies relative to military medical examinations,

b. Requirements for periodic, promotion, 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, and

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 U.S. Army medical facilities or accomplished for the U.S. Army.

10-3. Physical Fitness

Maintenance of physical fitness is an individual military responsibility, particularly with reference to remediable defects. Each member has a definite obligation to maintain himself in a state of good physical condition in order that he may perform his duties efficiently. Each individual, therefore, should seek timely medical advice whenever he has reason to believe that he has a medical condition or a physical defect which affects, or is likely to affect, his physical or mental well-being. He should not wait until the time of his 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 deter-

mining the existence of conditions requiring attention.

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 (to be published), 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 service member.

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 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 89 (when required) will be prepared. One copy of each will be retained by the examining facility and disposed of in accordance with AR 345-210. The other copy will be filed as a permanent record in the Health Record (AR 40-403) 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 should 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 Standard Form 88 (Report of Medical Examination) 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 Standard Form 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.

b. In general, medical examinations conducted for the Army will be accomplished at facilities of the Armed Forces, using military medical officers on duty or, full-time or part-time civilian physician employees.

c. Medical examinations conducted for the purpose of Army aviation program selection, training, assignment, or continuance, to include periodic, will be conducted only at military medical facilities of the Armed Forces where an aviation medical officer or flight surgeon is assigned or attached. (Designated flight surgeons and aviation medical officers of the reserve components of the Armed Forces may accomplish medical examinations for aviation personnel of the reserve components not on active duty.) Certain tests, procedures, or

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consultations may be conducted by other medical officers on request of an aviation medical officer or flight surgeon. However, in all such instances, the Standard Forms 88 and 89 must be reviewed and signed by the aviation medical officer or flight surgeon.

d. The periodic medical examination, required by AR 635-40-series 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 27, 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 an Armed Forces examining and entrance station) 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 authorized.

h. When required and/or indicated by the examining physician, enlisted medical personnel or civilian employees properly qualified by training and experience may conduct the following phases of the medical examination, recording results when appropriate, subject to verification of abnormal results by the physician:

- (1) Notes dictated by the physician.
- (2) Height and weight.
- (3) Visual acuity.
- (4) Color vision.

- (5) Auditory acuity (audiometry).
- (6) Electrocardiogram.
- (7) Blood pressure and pulse rate.
- (8) Drawing blood for serology.
- (9) Performing laboratory procedures.
- (10) Temperature.
- (11) X-rays.
- (12) Determining prescription of glasses by lensometer.
- (13) Prescribed physical exercises under the personal observation of the examining physician.

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 chapter 11 (to be published).

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 Standard Form 88 (Report of Medical Examination), item 40 of Standard Form 89 (Report of Medical History), and such other forms as may be required. See appendix IX and paragraph 10-15 for administrative procedures for filling out Standard Forms 88 and 89.

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 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 15 (examining facility or examiner, and address). Any help given the examinee will be only as an aid in his understanding of the questions, not as suggested answers. A Spanish version (Historia Medica) is available for use by Spanish speaking examinees. Standard Form 89 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, or (3) directed by Headquarters, Department of the Army.

b. Identification and Administrative Data. Items 1 through 16 will be completed as prescribed in paragraph 10-14e and appendix IX.

c. Medical History and Health Data.

- (1) *Item 17.* A brief statement by the examinee expressing his opinion of his 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 on his past medical history.
- (2) *Items 18 and 19.* A medical history of the examinee's family is entered to facilitate identification and evaluation of any familial, hereditary, or environmental conditions which may affect the examinee's current or future health.
- (3) *Examinee's medical history:* This includes items 20-39.
 - (a) Items 20 and 21 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 22A and B will be completed by all female examinees.
- (c) Items 23, 24, 25, and 26 will be completed by each examinee. Students who have not had full-time employment will enter the word "student" in item 25. 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 25.
- (d) Items 27 through 38—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 17 through 38 and, in the case of military personnel, the examinee's Health Record, cross-referencing his 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 was previously rejected for military service (item 37) or was discharged for medical reasons (item 38), the exact reasons

should be ascertained and recorded. Such examinee's, 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 606(5), AR 601-270). The same action is required in the case of an individual who checks "yes" for item 39.

- (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 examination, 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. Standard Form 89 (Report of Medical History) 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) Rescinded.
- (8) Deserters who return to military control.
- (9) Enlistment (initial) and reenlistment if validity period of separation examination has expired.
- (10) *General prisoners when prescribed.
- (11) Induction and preinduction pursuant to UMPS Act as amended.
- (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 U.S. military medical care is not readily available.
- (14) Mobilization of members of Army Reserve components.
- (15) Officer Candidate School.
- (16) *Oversea duty when prescribed except as outlined under Type B medical examination.
- (17) Periodic for Army Reserve components.
- (18) *Periodic for active duty members, other than Army aviation and diving.
- (19) Prisoners of war, when required, internees and repatriates.
- (20) ROTC: Enrollment in MST 5 and 6; USAR enlistment and enrollment in basic course (senior division) as participant in 4-year financial assistance program; USAR enlistment and enrollment in advance course (senior division) as participant in 2-year financial assistance program; USAR enlistment and enrollment in advanced course (senior division); applicant for membership in advanced course (senior division) upon arrival at basic field

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training camp; attendance at summer training camp; continuance in the program; and prior to appointment.

(21) Separation, resignation, retirement and relief from active duty. (SF 89 is not required in connection with separation examination for immediate reenlistment.)

c. Type B medical examination. A Type B medical examination is required to determine the medical fitness of personnel under the circumstances enumerated below. Standard Form 89 (Report of Medical History) 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 nonrated personnel not engaged in the actual control of aircraft, such as aviation medical officers, observers, etc. (SF 89 required for initial selection only.)

(2) Marine diving including selection, continuance or periodic annual medical examination. (SF 89 required for initial selection only.)

(3) U.S. Air Force Academy.

(4) U.S. Air Force Academy Preparatory School.

(5) U.S. Military Academy.

(6) U.S. Military Academy Preparatory School.

(7) U.S. Naval Academy.

(8) U.S. Naval Academy Preparatory School.

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) One year from date of medical examination to qualify for induction, enlistment,

reenlistment, appointment as a commissioned officer or warrant officer, active duty, active duty for training, advanced ROTC, OCS, admission to USMA Preparatory School, and USMA, all flying status, Classes I, IA, II, and III.

★(2) Six months from date of medical examination for separation from active duty including retirement. Individuals being processed for physical disability retirement are exempt from this requirement.

(3) Three months from date of Secretarial approval for reentry into the Army of members on the TDRL who have been found physically fit.

b. 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 for members of the Ready Reserve (para 10-31) within the past 4 years will be valid for the purpose of qualifying for immediate reenlistment in a Reserve component of Personnel not on active duty, provided there has been no change in the individual's medical condition since his last complete medical examination.

d. Medical examinations conducted at medical facilities of the U.S. Navy or U.S. Air Force or by other U.S. Government or civilian facilities for any of the purposes cited in *a*, *b*, or *c* above will, except for USMA Preparatory School and USMA, be considered acceptable medical examinations if they are of the proper scope prescribed by this chapter and are dated within the required validity periods. USMA qualifying examinations must be conducted at medical facilities of the Armed Forces listed in any service academy catalogs.

Section II. PROCUREMENT MEDICAL EXAMINATIONS

10-18. Procurement Medical Examinations
For administrative procedures pertaining to

procurement medical examinations (para 2-1) conducted at Armed Forces examining and en-

trance stations, see AR 601-270. For procedures pertaining to appointment and enlistment in the Reserve components, see AR

140-120 and NGR 27. For procedures pertaining to enrollment in the Army ROTC, see AR 145-120.

Section III. RETENTION, PROMOTION, AND SEPARATION MEDICAL EXAMINATIONS

10-19. General

This section sets forth administrative procedures applicable to retention (including periodic medical examinations), promotion and separation medical examinations (para 3-1).

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 135-90, 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 Medical Statement No. 2, DD Form 220 (Active Duty Report), or

(4) The individual requests a separation examination.

b. An individual on inactive duty training will be given a medical examination if—

(1) He incurs an injury during such training which may result in disability, or

(2) He alleges medical unfitness or disability.

c. Evaluation of medical fitness will be based on the medical fitness standards contained in chapter 3.

10-21. Health Records

a. Medical examiners will review the DD Form 722 (Health Record), AR 40-403, of

each examinee whenever an examination is conducted for the purpose of relief from active duty, resignation, retirement, separation from the service or when accomplished in connection with a periodic 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.

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

During mobilization, members of ARNGUS and USAR units who are individually called to active duty or collectively called to active duty with their respective units will undergo a medical examination as prescribed in AR 135-300. Individual members who are medically fit for retention or continuance in the Reserve components of the Army under the provisions of chapter 3 or chapter 8 are medically fit for mobilization.

10-23. Periodic Medical Examinations

a. *Applicability 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

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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.

- (2) Retired personnel are authorized, but not required, to undergo an annual medical examination. They will make advance arrangements with the medical examining station before reporting for such examination (DA Pam 608-2).
- (3) 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. DA Form 3081-R, Periodic Medical Examination (Statement of Exemption) will be prepared and submitted to unit commander for inclusion in DA Form 201 (Military Personnel Records Jacket, U.S. Army). DA Form 3081-R will be reproduced locally on 8- by 10½-inch paper in accordance with figure 10-1. The form number, title, and date will appear on each reproduced copy. The top margin of the form will be approximately ¼ inch to accommodate filing in DA Form 201 or DD Form 722 (Health Record), as appropriate.
- (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 S.F.); 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 component 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 (chaps. 1, 3, and 8 in the case of medico-dental registrants). 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) General considerations.
 - (a) All Report of Periodic Medical Examinations will be reviewed by the commanding officer of the medical examining facility or by a physician designated by him.
 - (b) Standard Form 88 that indicates a member has a remediable defect which interferes with his ability to perform duty will be retained by the examining facility until definite arrangements for correction or followup are made with the individual or the unit commander. Upon completion of arrangements for hospitalization or indicated treatment, a comment to that effect will be entered in item 75 and the Report of Periodic Medical Examination will be forwarded to the unit commander for action as prescribed in (c) below. The unit commander will then forward these reports to the custodian of the individual's health record for filing therein.
 - (c) When the SF 88 or DA Form 8-274 (Medical Condition—Physical Profile Record) reflects a change in the individual's physical profile serial or assignment limitations; or both, appropriate entries will be made on DA Form 20 (Enlisted Qualification Record) or DA Form 66 (Officers Qualification Record). Reports of such changes will be made to Headquarters, Department of the Army, as required by pertinent personnel regulations.

(8) The medical examination for general officers and full colonels should be performed on an individual appointment basis. The duplicate report (Standard Form 88) in the case of each general officer and full colonel will be forwarded to The Adjutant General, ATTN: AGPF-O, Department of the Army, Washington, D.C. 20310, for file in the individual's DA Form 201.

★(9) In addition to the periodic medical examination prescribed by c(2) below, all women in the Army on active duty; age 25 and over will undergo a breast and pelvic examination to include a Papanicolaou cancer detection test annually. This special examination 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 (DD Form 722).

b. Followup.

- (1) A followup visit will be arranged for an individual on active duty whenever the periodic medical examination reveals that there are diagnostic tests which should be repeated or that additional tests should be conducted in order to complete the evaluation. Arrangements will be made for the treatment or correction of conditions or remedial defects affecting the continued satisfactory performance of military duty or adversely affecting the examinee's health and well-being.
- (2) A Reservist who is not on active duty will be scheduled for followup appointments and consultations for the reasons stated in (1) above at Government expense when necessary to complete the examination. Treatment or correction of conditions or remediable defects discovered as a result of examination will be

scheduled if authorized. If the individual is not authorized treatment, he will be advised to consult a private physician of his own choice at his own expense.

c. Frequency.

- (1) An individual, whether or not on active duty, who is qualified under one of the classes for flying or as a marine diver will undergo a medical examination during the month in which his birthday anniversary occurs. In order to adjust an examination from the anniversary of the month in which the individual qualifies for flying or diving to his "birthday month," re-examination will be accomplished in the first "birthday month" after 3 but not more than 15 months following qualification. A similar one-time adjustment will be made in the periodic examinations of all individuals presently qualified for flying or marine diving.
- (2) Other military personnel on active duty are required to undergo a periodic medical examination during the anniversary months of their birthday ages as follows: 18, 21, 24, 27, 30, 32, 34, 36, 38, 40 and annually thereafter.
- (3) All members of the Ready Reserve and ARNGUS not on active duty—
 - (a) At least once every 4 years during the anniversary month of the examinee's last recorded medical examination. Major Army commanders and the Chief, National Guard Bureau, may, at their discretion, direct more frequent medical examinations in individual cases.
 - (b) Members of the Ready Reserve and ARNGUS not on active duty will accomplish a statement of medical fitness annually, on reporting for ANACDUTRA. The statement used

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will be "Medical Statement No. 1" on the reverse of DD Form 220 (Active Duty Report).

- (4) 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 (DD Form 722) and on Health Record—Chronological Record of Medical Care (SF 600) when such a situation exists.
- (5) 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 Condition.

- (1) Any change in physical profile or limitations found on periodic medical examination will be reported to the unit commander on DA Form 8-274 (Medical Condition—Physical Profile Record) as prescribed in chapter 9.
- (2) Retired personnel will be informed of the results of medical examination 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. Reserve component officers and warrant officers not on active duty who have been selected for promotion will be considered medi-

cally qualified for promotion on the basis of a Type A medical examination accomplished within 1 year of the effective date of promotion.

10-25. Separation Including Retirement

a. Except as noted below, all military personnel, including U.S. Military Academy cadets, on active duty or active duty for training in excess of 30 days are required to undergo a medical examination prior to separation. The exception to this requirement applies to those individuals separated under the provisions of paragraph 3b, AR 635-205, for the purpose of immediate enlistment or reenlistment. A separation medical examination is not required for these individuals. The following schedule of separation medical examinations is established:

- (1) Individuals on active duty or active duty for training for a period of 1 to 6 months will be examined not earlier than 30 days nor later than 15 days prior to the scheduled date of relief from active duty or active duty for training.
- (2) Individuals on active duty, or active duty for training in excess of 6 months will be examined not earlier than 6 months nor later than 2½ months prior to the scheduled date of termination of active duty status.
- (3) Cadets separated from the U.S. Military Academy prior to graduation will be examined prior to separation.
- (4) Under exceptional circumstances, where conditions of the service preclude the accomplishment of the separation medical examination within the time prescribed, it may be deferred by direction of the commander having custody of the field personnel file until such time as its accomplishment becomes feasible, but in no event later than 3 working days prior to departure from the place of transfer processing. Appropriate entries will be made in the Health Record when such a situation exists.

b. DA Form 3082-R (Statement of Medical Condition—When Examined More Than 3 Days

Prior Separation) will be reproduced locally on 8- by 10½-inch paper in accordance with figure 10-2. The top margin will be approximately ¾ inch to accommodate filing in Health Record. The form will be signed upon separation by those individuals required to undergo a separation medical examination and who undergo

such examination more than 3 working days prior to date of departure from place of separation. If exceptions are noted, the member will be re-examined prior to separation. The statement will be attached to the separation Report of Medical Examination (SF 88) filed in the Health Record.

Section IV. FLYING DUTY MEDICAL EXAMINATIONS

10-26. Flying Duty

a. 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, and psychiatric examinations as well as to a detailed elaboration of pertinent data on the Report of Medical History (SF 89). 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.

b. Definitions. For the purpose of this section the following terms will be employed with the meanings given:

- (1) *Aerial flight.* Aerial flight is a journey in an aircraft. It begins when the aircraft takes off from rest at any point of support and terminates when it next comes to a complete stop at a point of support. See AR 95-1 and AR 37-104.
- (2) *Designation.* The term designation is used to mean currently effective aeronautical appointment granted by the Chief of Staff, United States Army, or other properly designated authority. See AR 95-1 and AR 600-106.

- (3) *Designated or rated personnel.* The term designated or rated personnel includes officers, warrant officers, and enlisted personnel who hold a currently effective aeronautical designation or rating.
- (4) *Excusal.* When an individual on flying is incapacitated for flying by reason of an aviation accident, he will not be required to perform aerial flights during such incapacity for a period not to exceed 3 months. He will not be suspended from flying status during this period, but will be excused from meeting flight requirements and thereby will be eligible for flying pay. This action is termed excusal. If, following the 3-month period during which the individual is not required to perform aerial flights, he is not medically qualified for flying, action will be initiated recommending that he be suspended, either temporarily or indefinitely, from flying status. See AR 37-104.
- (5) *Flying status.* Flying status is an official standing in which an individual has been ordered by proper authority to participate in regular and frequent aerial flights. See AR 37-104.
- (6) *Rating.* The term rating means currently effective aeronautical ratings officially granted by the Chief of Staff, U.S. Air Force, or other properly designated authority.
- (7) *Serious illness or serious injury.* This term means any illness or injury that is adjudged by competent medical authority to have future significance

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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 interfering with normal binocular visual function.

- (8) *Suspension.* Suspension is withdrawal of an individual's authority to participate in regular and frequent aerial flights.

c. *Disqualification.*

- (1) When a commander believes an individual 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 (g below). 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 their contents are of paramount importance.
- (2) Personnel donating blood will not perform flying duty for a period of 72 hours following the donation. If he deems it necessary, the medical examiner may recommend suspension in accordance with paragraph 4a(4), AR 600-107.
- (3) 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.
- (4) A finding of qualification or disqualification for flying duty in any specific

capacity will be made on the basis of the medical examination. Elaboration of this recommendation 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 nevertheless will be disqualified.

- (5) 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 commanding officer of the examinee concerned in writing and in the most expeditious manner feasible. This officer will act on the basis of such notification. An individual will not be restored to flying status until he is again able to qualify medically or has received a waiver for his disqualifying defect granted by duly constituted authority. (See sec III, chap 2, AR 37-104 and AR 600-107.)

d. *Filing.* Reports of medical examination for flying (including clinical medical summaries, etc.) will be put in the Individual Flight Record File as prescribed in AR 95-64. In addition, appropriate entries, such as prescriptions for glasses to be worn while flying, will be made in item 25, DA Form 759 (Individual Flight Record—Army Aviator).

e. *Medical Examination Reports.*

- (1) Complete reports of medical examination for flying accomplished in conjunction with application for flight training pursuant to AR 611-85 and AR 611-110 will be forwarded directly to the commander having personnel jurisdiction over the applicant. In no case will completed reports of medical examination be given to the applicant. Reports of medical examination for flying accomplished other than for flight training will be reviewed in

accordance with paragraph 10-24 or AR 600-107, as appropriate; if forwarded to The Surgeon General for review, the reports will include one copy of Standard Form 89.

- (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 Agency certification will be as prescribed by AR 40-2. A third copy of Standard Form 88 will be prepared if the individual desires a medical certificate from the Federal Aviation Agency.

f. Scope. The prescribed Type B medical examination will be conducted in accordance with the scope specified in appendix IX and as outlined in TB MED 244.

g. Suspensions. Sick in hospital, sick in quarters, or sick leave status will be considered prima facie evidence of medical disqualification for flying duty. All suspensions are issued by written order. When suspension is for a minor illness or injury, not the result of an aviation accident, and is of a duration less than 30 days, it will be handled locally without reference to higher authority. Suspension of over 30 days and less than 6 months will be reported for confirmation to higher headquarters. Normally, this authority rests with a major command; however, it may be delegated to a subordinate command. Cases concerning suspensions for a serious illness or injury or suspensions which are expected to or do exist for greater than 6 months will be reported to Headquarters, Department of the Army for confirmation. Complete medical reports (including Standard Forms 88 and 89 and necessary consultations, if any) will accompany such cases. All suspensions of civilian flight instructors and test

pilots employed by the Department of the Army will be handled locally, whenever possible; however, the authority for confirmation of removal of suspension lies at the same level as that required for confirmation of the original suspension. See AR 600-107.

h. 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 a 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 when a medical question is involved.
- (3) All personnel of the operating aircraft crew involved in an aircraft accident, if it appears that there is any possibility, whatsoever, that medical considerations may have been instrumental in causing, or should be investigated as a result of, such accident. An aviation medical examiner or other qualified medical officer will screen the crew members at the earliest practicable time to determine if a Type B medical examination is necessary.

i. Waivers.

- (1) *General.* A separate request for waiver need not accompany a Report of Medical Examination. Recommendation concerning waivers will be made on the Report of Medical Examination. 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 letter-size paper. Waiver of minor defects will in no way compromise flying safety or affect the efficient per-

formance of flying duty or the individual's well-being.

- (2) *Designated or rated personnel.* Designated or rated personnel who by reason of minor defects do not meet the requirements of this regulation may request a waiver from The Adjutant General, ATTN: AGPO-AE, Department of the Army, Washington, D.C. 20315.
- (3) *Initial applicants.* On the examination for flying training, rating, or designation, waivers will not be requested by an examinee or examination medical officer. However, if the examinee has a minor physical defect, a complete medical examination for flying will be accomplished and details of the defect recorded. The report will be attached to application for aviation training and forwarded as prescribed in the regulations applicable to the procurement program under which the application is submitted.
- (4) *Nondesignated or nonrated personnel.* In nondesignated or nonrated personnel, minor physical defects which will in no way affect the efficient performance of flying duties will be waived by the commander of the unit or station upon recommendation of a qualified medical officer. Notification of such disqualification will be forwarded, in all instances in writing, by the hospital commander or the medical officer concerned to the disqualified individual's commanding officer with appropriate recommendations for suspension

from flying status in accordance with existing directives. See AR 37-104 and AR 600-107.

★*j. Review and Waiver Action.* The commander of a major command, the Commandant of the Army Aviation School and the Commanding Officer, U.S. Army Primary Helicopter Center, are authorized to make final determination of the medical qualifications for continuance on flying status of aviation personnel permanently assigned to duty in their commands. This same authority is delegated to the Chief, National Guard Bureau, for members of the National Guard not on active duty and includes authority to—

- (1) Grant administrative waivers for physical defects and medical conditions which unquestionably do not compromise the individual's health or flying safety, but not below the medical fitness standards (exclusive of para 3-3) contained in chapter 3.
- (2) Impose intermediate suspension (AR 600-106 and AR 600-107).
- (3) Make final certification as to the medical qualification for flying or aviation officers:
 - (a) Who are under consideration for—
 1. Intermediate suspension,
 2. Revocation of intermediate suspension, or
 3. Recession of such suspension.
 - (b) Who are permanently assigned to duty within the jurisdiction of that command, school, or chief.

Section V. USMA MEDICAL EXAMINATIONS

10-27. U.S. Military Academy

a. General. This section sets forth administrative procedures applicable to medical examinations of candidates and prospective candidates for the U.S. Military Academy, other service academies, and the respective preparatory schools (chap. 5).

b. Distribution of Medical Reports. Upon completion all medical reports (the originals only of SF 88, SF 89, and supplemental reports) to include X-rays of abnormalities, photographs and dental casts, will be forwarded as follows:

- (1) United States Military Academy: The Surgeon General, ATTN: MEDPS-SP, Department of the Army, Washington, D.C. 20315. The Adjutant General will transmit copies of all such reports to the Superintendent, United States Military Academy, West Point, N.Y. 10996, and make other required distribution.
- (2) United States Naval Academy: Superintendent, United States Naval Academy, Annapolis, Md. 21402.

- (3) United States Air Force Academy: Superintendent, United States Air Force Academy, Colorado Springs, Colo. 80840.
- (4) If the examinee indicates he is an applicant for more than one service academy, the originals of all medical reports will be forwarded to the service indicated as his first choice. Duplicates suitable for copying will be forwarded to the other specified service(s) as appropriate and as noted above.

c. Facilities and Authorization for Examination. Qualifying medical examination (Type B) of applicants or nominees for admission to Service academies are accomplished at medical facilities designated for this purpose and listed in the current catalogs of the academies. Individuals will be examined on presentation of a signed written request from one of the following:

- (1) Congressional: The Member of Congress concerned.
- (2) Competitive: The Adjutant General, Department of the Army; the Chief of Naval Personnel, Navy Department; or the Director of Admissions, U.S. Air Force Academy.
- (3) Sons of Persons Awarded the Medal of Honor: Same as (2) above.

d. Preparatory School. A member of the Army being considered for attendance at the U.S. Military Academy Preparatory School is not required to undergo medical examination specifically to qualify for selection. A medical officer will review his Health Record and most recent Report of Medical Examination and, using the medical fitness standards of chapter 5, will arrive at a conclusion as to the probability of the applicant meeting medical fitness requirements for admission to the Academy. The reviewing medical officer may direct the accomplishment of any necessary tests or procedures that he feels necessary to resolve any questionable area(s) of medical fitness. The results will be entered in item 73 of the individual's

most recent Report of Medical Examination which will be forwarded with his application. Tests or further examination will be limited to those instances where the physician's review of the record indicates that the applicant may not be medically qualified for entrance into the U.S. Military Academy. A Type B medical examination will eventually be conducted at the Preparatory School.

e. Release of Examination Results. Examinees may be advised as to existence of remediable medical or dental defects, but no commitment is to be made as to qualification or disqualification of any examinee regardless of circumstances. Copies of Report of Medical Examination will not be furnished examinees or sponsors. Requests, oral or written, for medical information concerning Air Force or Naval Academy examinees will be referred to the appropriate academy superintendent. Requests pertaining to USMA examinees will be referred to The Adjutant General, ATTN: AGPB-M, Department of the Army, Washington, D.C. 20315.

f. Scope. Qualifying medical examinations for the U.S. Military Academy, the U.S. Naval Academy and the U.S. Air Force Academy will be of the scope prescribed for Type B examinations.

g. Standard Form 88 (Report of Medical Examination).

- (1) *Additional information.* The following information will be included on all copies of reports of qualifying medical examination in addition to that required by paragraph 10-14 and appendix IX.
 - (a) An entry in item 5 such as "USMA", "USNA" and/or "USAFA".
 - (b) The name of the person requesting the examination and, if applicable, his title or position, in item 16.
 - (c) An appropriate note will be entered identifying X-ray films and any photographs of dental casts transmitted with the form.

- (d) Item 77 as to whether the applicant or nominee is qualified or disqualified for the United States Military Academy or the United States Naval Academy, as applicable, may be completed as a recommendation of the examining physician. In the case of a United States Air Force Academy applicant or nominee, no entry will be made in item 77.
- (e) The report of medical examination will be signed by at least one medical examiner and one dental examiner.
- (2) *Dental examination.* The following procedures apply to all dental examinations conducted in connection with U.S. Military Academy qualification.
- (a) Notation will be made concerning the serviceability of dentures or bridges.
- (b) Defects, infections, and periodontal disease, described as to severity, will be listed.
- (c) An examinee wearing appliances for active orthodontic treatment will be requested to obtain from his attending orthodontist a written statement indicating the expected date by which the orthodontic appliances may be removed or replaced by retainer type appliances.
- (d) Casts of the upper and lower arches will be made only when the conditions listed in paragraphs 5-5b, c(2), and d(2) are found. At least three pencil marks will be drawn across both casts to indicate the closed position, and the examinee's name will be placed on each cast. When a cast is required of an arch supporting a removable prosthesis the impression will be made with the appliance in place whenever practicable. No cast is required of an edentulous arch which supports no prosthetic appliance unless the relationship between the mandible and maxilla precludes future satisfactory prosthetic replacements, in which case articulator mounting is indicated. In such cases the condition will be fully described in item 44 and/or items 73 and 74.
- h. DD Form 1525 (Personal History Questionnaire—Medical Examination—U.S. Armed Forces Service Academies).*
- (1) All applicants and candidates for admission to the United States Military Academy, United States Naval Academy, and the United States Air Force Academy as a part of their medical examination, are required to complete one copy of DD Form 1525.
- (2) The DD Form 1525, when completed by the examinee, will be used by the examiners who conduct the psychiatric phase of the medical examination. The Questionnaire will be carefully reviewed by the examiner, and elaborated upon in the space provided for the interviewer's comments. A rating of "satisfactory" or "unsatisfactory" will be recorded in the space provided. Such rating will reflect the examiner's comments.
- (3) The examinee will not be disqualified solely on the basis of information contained in the DD Form 1525. Any psychiatric problem elicited by the examiner, as a result of review of the Questionnaire and personal interview with the examinee, must be confirmed by clinical evaluation, and a diagnosis definitely established.
- (4) The DD Form 1525, when completed by the examinee and examiner, becomes a part of the Report of Medical Examination, and will be attached to the original Standard Form 88 to be forwarded to appropriate reviewing officials.
- i. Standard Form 89 (Report of Medical History).* A complete and accurate medical history must be compiled with particular care. The applicant or nominee will provide full explanation of all diseases, including those of a familial nature, injuries and operations affecting his

medical status. The examining physician will thoroughly investigate all questionable areas, carefully evaluate the report, and summarize

all pertinent data under item 40.

j. Waivers. See paragraphs 1-4, 7-14, and 10-14c.

Section VI. MOBILIZATION MEDICAL EXAMINATIONS

10-28. Mobilization Medical Examinations

For administrative procedures applicable to

mobilization 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 regulations such as AR 601-210, AR 611-7, AR 611-15, AR 611-75, AR 611-101, AR 611-112, AR 611-201, DA Pam 350-10, TB Med 267, and chapter 7.

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 attachés, military missions, military assistance advisory groups, or in isolated areas, the commander of the station to which he is assigned will refer the individual and his 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 7-9 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 Health Data Publications of the Walter Reed Army Institute of Research 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 in-

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 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 review of available medical records, discussion with the individual and his dependents, and findings of the medical examination, if accomplished, the physician finds them medically qualified in every respect under paragraph 7-9d, and to meet the conditions which will be encountered in the area of contemplated assignment, he will complete and sign DA Form 3083-R (Medical Examination for certain Geographical Areas). This form will be reproduced locally on 8- by 10½-inch paper in accordance with figure 10-3. The top margin of form to be approximately ¾ inch for filing in Health Record and Outpatient Record. A copy of this statement will be filed in the Health Record (AR 40-403) or Outpatient Record (AR 40-425) 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 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 parent 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 8-118 (Medical Board Proceedings) or DA Form 8-274 (Medical Condition—Physical Profile Record) may be used, the selection depending on the eventual use of the report.

- (4) Periodic medical examinations and medical examinations conducted for the purpose of separation and immediate reenlistment may be waived by the commanding officer concerned for those individuals stationed in isolated areas; i.e., Army attachés, military missions and military assistance advisory groups, where medical facilities of the U.S. Armed Forces are not available. Medical examinations so waived will be accomplished at the earliest opportunity when the individuals concerned are assigned or attached at a military installation having a medical facility. Medical examination of such individuals for separation or retirement purposes may not be waived.

**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. Also see chapter 8.

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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, etc.) or involuntary (induction, etc.).

3. Enlistment

The voluntary enrollment for a specific term of service in one of the Armed Forces as contrasted with induction under the Universal Military Training and Service Act of 1948, as amended.

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 perform 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.

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APPENDIX IV
JOINT MOTION MEASUREMENT
(TM 8-640)

1. THE HIP



FIGURE 1

2. THE KNEE

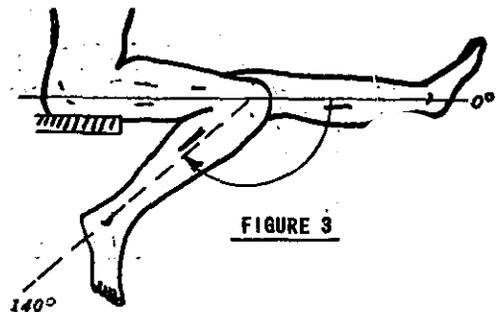


FIGURE 3

FLEXION

- a - POSITION - Supine, knee flexed; opposite knee and hip straight
- b - STATIONARY ARM* - Parallel to long axis of trunk.
- c - MOVING ARM* - In line with lateral midline of femur.



FIGURE 2

EXTENSION AND FLEXION

- a - POSITION - Sitting with knee flexed.
- b - STATIONARY ARM* - Parallel to femur on a line from the lateral condyle to greater trochanter.
- c - MOVING ARM* - Parallel to fibula on line with lateral malleolus.

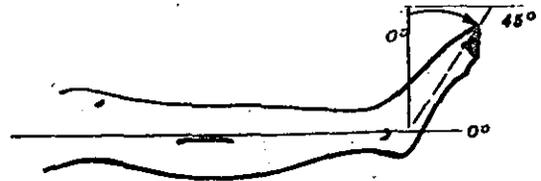


FIGURE 4

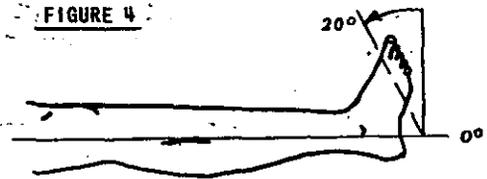


FIGURE 5

EXTENSION

- a - POSITION - Prone
- b - STATIONARY ARM* - Parallel to long axis of trunk.
- c - MOVING ARM* - In line with lateral midline of femur.

PLANTAR FLEXION & DORSIFLEXION

- a - POSITION - Supine with heel over edge of table and knee extended.
- b - STATIONARY ARM* - Parallel to fibula.
- c - MOVING ARM* - In line with the lateral edge of the heel and the head of the 5th metatarsal.

(*) For purposes of this regulation, stationary arm and moving arm refer to the stationary and moving portions of the goniometer.

JOINT MOTION MEASUREMENT - Cont.

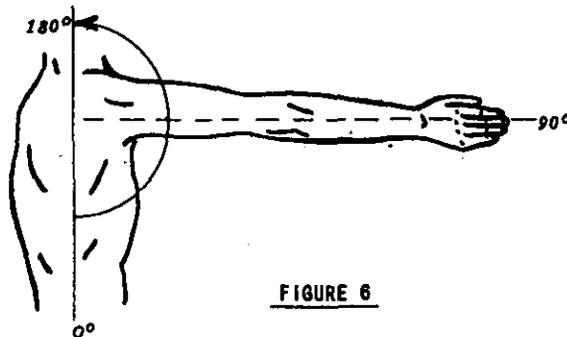
4. THE SHOULDER

FIGURE 6

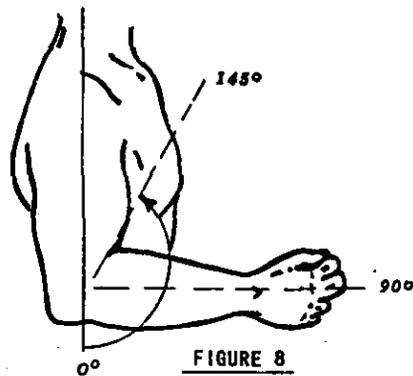
5. THE ELBOW

FIGURE 8

FLEXION

- a - POSITION - Standing, sitting or supine with elbow extended. Palm facing medially. Measure from lateral aspect of body.
- b - STATIONARY ARM* - Along mid-axillary line of trunk.
- c - MOVING ARM* - Along lateral midline of humerus.

EXTENSION AND FLEXION

- a - POSITION - Standing, sitting or supine. Forearm in mid-position between supination and pronation.
- b - STATIONARY ARM* - Along midline of humerus.
- c - MOVING ARM* - Along midline of dorsal aspect of forearm.

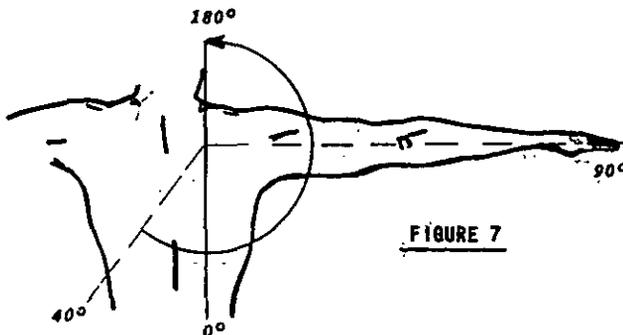


FIGURE 7

ADDUCTION AND ABDUCTION

- a - POSITION - Standing or sitting.
- b - STATIONARY ARM* - Parallel to spine but at lateral aspect of body.
- c - MOVING ARM* - Parallel to midline of humerus toward olecranon process.

(*) For purposes of this regulation, stationary arm and moving arm refer to the stationary and moving portions of the goniometer.

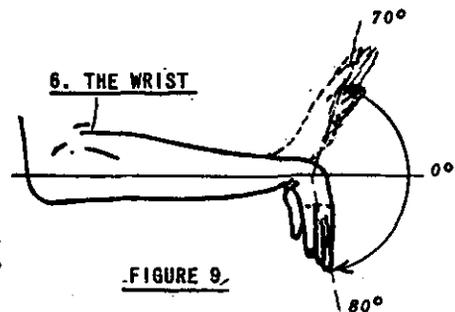


FIGURE 9

EXTENSION AND FLEXION

- a - POSITION - Sitting or standing with elbow flexed and forearm in pronation.
- b - STATIONARY ARM* - Along lateral midline of forearm.
- c - MOVING ARM* - Parallel to 5th metacarpal.

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★APPENDIX IX
SCOPE AND RECORDING OF MEDICAL EXAMINATIONS

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
1	✓	✓	The entire last name, first name, and middle name are recorded. If the individual's first and/or middle name consists of initial(s) only, indicate by adding (IO). When Jr. or similar designation is used, it will appear after the middle name. If there is no middle name or initial, put a dash after the first name.	Jackson, Charles Guy Rush, Benjamin— Osler, William Z. (IO) Jenner, Edward Thomas Jr. Baird, J.T.
2	✓	✓	Enter examinee's grade and component. The entry USA is used for all personnel on active duty with the United States Army. Reserve components of the Army are indicated by USAR or ARNGUS. If examinee has no military status, enter the word "civilian," leaving space for later insertion of grade and component upon entry into the military service.	Capt., USA Maj., USAR Sgt., USA SFC, ARNGUS Civilian
3	✓	✓	Examinee's military service number. Proper letter prefix or suffix is part of the service number. If examinee is a civilian, enter a dash.	RA 33157999 05309164 ER 6842901 NG 16832752
4	✓	✓	Examinee's current civilian mailing address. Do not confuse with military organization or present temporary mailing address.	3601 S. Oak Street Richmond, Ind 20316
5	✓	✓	Enter purpose of examination. If for more than one one purpose, enter each.	Induction RA Enlistment Periodic RA Commission Retirement
6	✓	✓	Enter date on which the medical examination is accomplished. Record in military style. This item is to be completed at the medical examining facility.	10 Feb 1965 3 Mar 65
7	✓	✓	Do not use abbreviation.	Male Female
8	✓	✓	As appropriate, enter the first three letters of one of the following: Caucasian, Negroid, Mongolian, Indian (American) or Malayan. Do not confuse with nationality or religion.	Cau Neg Mon Ind (American) Mal
9	✓	✓	Enter total active duty time in the military and/or full time Civil Service or Federal employment only. Express as years plus twelfths. Reserve time may be entered in item 16.	7 6/12; 4 3/12
10	✓	✓	Enter branch of military Service or civilian agency as appropriate. Do not confuse with components of the services.	DA FBI DAF CIA DN State Dept USMC
11	✓	✓	The examinee's current military unit of assignment, active or reserve. If no current military affiliation, enter a dash.	
12	✓	✓	Record in military style, i.e., day, month and year, followed by age, in parentheses, to the nearest birthday.	14 Jan 43 (21) 26 Mar 20 (45)
13	✓	✓	Name of city and state of examinee's birth. If not born in a city or town, enter county and state. If born in a foreign country, enter city or town and country.	Baltimore, Md. Dinwiddie County, Va. Marseilles, France

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
14	✓	✓	Name, followed by relationship in parentheses, and address of next of kin. This is the person to be notified in the event of death or emergency. If there is no next of kin, enter "none".	Mrs. Anne F. Harris (Wife) 1234 Fairfax Ave. Atlanta, Ga. 20527
15	✓	✓	Name of examining facility or examiner and address.	Armed Forces Examining Station 310 Gaston Ave. Fairmont, W. Va. 12441 Dr. Raymond T. Fisher 311 Marcy Street Phoenix, Ariz. 39404
16	✓	✓	List any prior service number(s) and service(s). In the case of service academy examinees, enter the title, full name, and address of sponsor (individual who requested the examination). For Selective Service registrants list the examinee's Selective Service number and identify as such. Identifying or administrative data for the convenience of the examining facility should be entered either in item 16, if space allows, or otherwise in the upper right hand corner of the SF 88. If the examination is for an aviation procurement program and the examinee has prior military service, enter the branch of service.	
17	✓	✓	The individual's current military job or specialty, including total time in this capacity expressed in years and/or twelfths. In the case of pilots, enter current aircraft and total flying time in hours.	
18	✓	✓	Record all swollen glands, deformities, or imperfections of head or face. In the event of detection of a defect of the head or face, such as moderate or severe acne, cyst, exostosis, or scarring of the face, a statement will be made as to whether this defect will interfere with the wearing of military clothing or equipment. If enlarged lymph nodes of the neck are detected they will be described in detail and a clinical opinion of the etiology will be recorded.	2 in. vertical scar right forehead, well healed, no symptoms. 3 discrete, freely movable, firm 2 cm. nodes in the right anterior cervical chain, probably benign.
19	✓	✓	Record all abnormal findings. Record estimated percent of obstruction to air flow if septal deviation, enlarged turbinates, or spurs are present.	20 percent obstruction to air flow on right due to septal deviation.
20	✓	✓	Record all abnormal findings.	Marked tenderness over left maxillary sinus.
21	✓	✓	Record any abnormal findings. If tonsils are enucleated, this is considered abnormal, thus check this item abnormal.	Tonsils enucleated.
22	✓	✓	If operative scars are noted over the mastoid area, a notation of simple or radical mastoidectomy will be entered.	Bilateral severe swelling, injection and tenderness of both ear canals.
23	✓	✓	Record all abnormal findings. If tested, a definite statement will be made as to whether the ear drums move on valsalva maneuver or not. In the event of scarring of the tympanic membrane the percent of involvement of the membrane will be recorded as well as the mobility of the membrane.	Valsalva normal bilaterally. 2 mm oval perforation, left posterosuperior quadrant. No motion on valsalva maneuver, completely dry. No evidence of inflammation at present.

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Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
45 A B C D	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	Identify tests used and record results. Items A and D are not routinely required for chargeable accessions; only if indicated.	
46	✓	✓	Note film size, number, date and place taken and findings. A report of chest X-ray accomplished within the preceding 12 months may, at the discretion of the examining physician, be accepted in lieu of a current chest X-ray. Note facility, place and date taken, film size, number, wet or dry reading and findings. Reading must be by radiologist, or internist experienced in radiology.	14 x 17 film No. 54321 Letterman General Hospital, San Francisco, Calif., 8 December 1964, dry reading, negative.
47	✓	✓	Kahn, Wasserman, VDRL, or cardiolipin microfloculation tests recorded as negative or positive. On positive reports note date, place and titre. Serology not required for periodic examination.	Cardiolipin. Microfloculation. Negative. Normal. Abnormal—see attached report.
48	(*)	✓	*Required for retirement or if age 40 or over; also if indicated. Representative samples of all leads (including precordial leads) properly mounted and identified on Standard Form 520 (EKG report) will be attached to the original of SF 88. Standard Form 520 should be attached to all copies of SF 88. The interpretation of the EKG will be entered in item 48 (or 73 if necessary) on all copies of SF 88.	Normal. Abnormal—see attached report.
49	(*)	(*)	★*Only required for initial appointment and enlistment in USAR and ARNG without concurrent active duty.	
50	(*)	(*)	*Only if indicated. Identify test(s) and record results.	
51	✓	✓	Record in inches to the nearest quarter inch (without shoes).	71½.
52	✓	✓	Record in pounds to the nearest whole pound, (without clothing and shoes).	164.
53	✓	✓	Record as black, blond, brown, gray or red.	Brown.
54	✓	✓	Record as blue, brown, gray or green.	Blue.
55	✓	✓	Enter X in appropriate space. If obese, enter X in two spaces as appropriate. For definition of obesity see appendix I.	
56	(*)	✓	*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6°.
57 A, B and C	(*)	✓	Record sitting blood pressure for all examinations. *Only if indicated by abnormal findings in A, i.e., if sitting blood pressure is 140/90 or more for individuals below age 35, or 150/90 for those age 35 and above. Any abnormal reading should be rechecked by recording blood pressure readings twice a day (morning and afternoon) for 3 consecutive days.	110/76
58 A	✓	✓	Record for all examinees.	
B, C, D and E	(*)	✓	*Record only if indicated by abnormal findings in 58A, i.e., if A is 100 or more, or below 50. If either D or E	

App IX

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
59	✓	✓	is 100 or more, or less than 50, record pulse twice a day (morning and afternoon) for 3 days and enter in item 73. Also record average pulse in item 73. Record in terms of the English Snellen Linear System (20/20, 20/30, etc.) of the uncorrected vision of each eye. If uncorrected vision of either eye is less than 20/20, entry will be made of the corrected vision of each eye.	20/100 corr. to 20/20. 20/50 corr. to 20/20.
60	(*)	✓	Refraction required for induction enlistment and appointment if <i>corrected</i> vision is less than the minimum visual standards stated in paragraph 2-13a, or if deemed appropriate by the examiner regardless of visual acuity. ★Cycloplegic required for initial selection for service academies and preparatory schools, diving and Class I, IA flying duty thereafter only if determined desirable by the examiner. The word "manifest" or "cycloplegic," whichever is applicable, will be entered after "refraction." An emmetropic eye will be indicated by plano or 0. For corrective lens, record refractive value.	By -1.50 S+0.25 CX 05. By -1.50 S+0.25 CX 175.
61	✓	✓	Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20) an entry will be made of the corrected vision for each eye and lens value after the word "by."	20/40 corr. to 20/20 by same. 20/40 corr. to 20/20 by +0.50.
62	—	✓	Identify the test used, i.e., either the Maddox Rod Test or the Armed Forces Vision Tester, and record results. Prism Div and PD not required. Not required for dependents.	Armed Forces Vision Tester. ES° 4 EX° 0 R.H. 0 L.H. 0 Prism Div.CT Ortho PC 35 PD.....
63	—	✓	Record values without using the word "diopters" or symbols.	Right 10.0 Left 9.5.
64	✓	✓	Required only as initial test and subsequently only when indicated. Not required for dependents. Record results in terms of the test used, pass or fail, and number of plates missed over the number of plates in the test. If examinee fails Pseudoisochromatic Test, he will be tested for red/green color vision and results recorded as "passed" or "failed red/green."	Pseudoisochromatic Plate Set Fail 6/17 Passed red/green.
65	—	✓	Identify test used and record results for uncorrected and corrected. Enter dash in corrected space if applicable. Score is entered for Howard-Dolman; passes or fails is used for Verhoeff.	Howard-Dolman 25. Verhoeff passes.
66	—	✓	Identify test used and results. If a visual field defect is found or suspected in the confrontation test, a more exact perimetric is made using the perimeter and tangent screen. Findings are recorded on visual chart and described in item 73. Copy of chart must accompany original SF 88.	Confrontation test: Normal, full.

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Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
67	—	(*)	*Only if indicated by history, record results. If not indicated enter NIBH.	NIBH.
68	—	✓	Record test results and describe all abnormalities.	Normal.
69	(*)	(*)	*Only if indicated. Tonometry on all personnel age 40 and over. Record results numerically in millimeters of mercury of intraocular pressure. Describe any abnormalities; continue in item 73 if necessary.	Normal. O.D. 18.9. O.S. 17.3.
70	—	—	Not required. Enter dash in each space.	
71	✓	✓	Test and record results at 500, 1000, 2000, and 4000 cycles and except for service academies for which 3000 and 6000 will also be tested and results recorded.	

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Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
72	(*)	✓	*Only if indicated. Adaptability Rating for Military Aeronautics (ARMA) required for Army Aviation. Enter as "ARMA satisfactory" or "ARMA unsatisfactory." Unsatisfactory ARMA requires a summary of defects responsible for failure in item 73. ARMA, Reading Aloud Test (RAT) and DD Form 1525, required for service academies and preparatory schools. Results of other psychological testing, when accomplished, will be attached to SF 88.	ARMA sat. ARMA unsat.— See item 73.
73	✓	✓	If SF 89 is not used, the examinee will enter a brief statement about the state of his health since his last examination. Examiner will enter notes on examination as necessary. Significant medical events in the individual's life such as major illnesses or injuries, and any illness or injury since the last in-service medical examination will also be entered. Such information will be developed by reviewing health record entries and questioning the examinee. Complications or sequelae, or absence thereof will be noted where appropriate. Do not use "NS." Comments from other items may also be continued in this space. If additional space is needed, use SF 507. History and related comments recorded on SF 89, when this form is used, will not be transferred or commented on except as necessary in connection with the examination.	No significant or interval history. Traumatic cataract, left eye, removed 29 July 1964, no comp., see item 59-60 for vision correction. Item 72 cont: History of multiple idiopathic syn-copal attacks.
74	✓	✓	Summarize medical and dental defects considered to be significant. Those defects considered serious enough to require disqualification or future consideration, such as waiver or more complete survey, must be recorded. Also record any defect which may be of future significance, such as non-static defects which may become worse. Enter item number followed by short, concise diagnosis; do not repeat full description of defect which has already been described under appropriate item. Do not summarize minor, nonsignificant findings.	
75	✓	✓	Notation will be made of any further specialized examinations or tests that are indicated. Item 75 will also include the statement "gas mask spectacles required (AR 40-3)" whenever indicated under the criteria set forth in AR 40-3.	
76	✓	✓	The physical profile as prescribed in chapter 9 will be recorded.	1 1 1 1 2 1
77	✓	(*)	*Except as noted below, check box A or B, as appropriate, and enter purpose of the examination as stated in item 5. Though not required, this item may be completed as a recommendation of the examining physician in the case of applicants or nominees for the USMA or the USNA. No entry will be made for USAFA applicants or nominees.	
78	✓	✓	List all disqualifying defects by item number, This listing is required even though the defects are stated in item 74. If qualified enter a dash.	

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
79-81	✓	✓	Enter typed or printed name of physician and dentist as appropriate. The Report of Medical Examination accomplished for the purpose of entrance to the USMA, USAFA or USNA will be signed by a physician and a dentist. The Report of Medical Examination for Army Aviation Program personnel will be signed by an aviation medical officer or flight surgeon. All other reports will be signed by at least one physician. When the dental examination is performed by a dentist, the report will also be signed by a dentist. Signatures will be in black or blue-black ink only. Initials may be used for authentication of copies of Standard Form 88. Whenever the Standard Form 88 is reproduced and the original signature is clearly legible on the copy, no initials or signature is needed to authenticate the report.	
82	(*)	(*)	*See paragraph 10-14d.	

l. Recent fracture of ribs, sternum, clavicle, or scapula.

m. Significant abnormal findings on physical examination of the chest.

2-25. Tuberculous Lesions

(See para 2-38.)

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

★*a. Tuberculosis*, active at any time within the past two years, in any form or location. A positive tuberculin skin test without other evidence of active disease is not disqualifying. Individuals taking prophylactic chemotherapy because of recent skin test conversion are not disqualified.

★*b. Rescinded.*

c. Substantiated history of one or more reactivations or relapses of pulmonary tuberculosis, or other definite evidence of poor host resistance to the tubercle bacillus.

2-26. Nontuberculous Lesions

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

a. Acute mastitis, chronic cystic mastitis, if more than mild.

b. Bronchial asthma, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday.

c. Bronchitis, chronic with evidence of pulmonary function disturbance.

d. Bronchiectasis.

e. Bronchopleural fistula.

f. Bullous or generalized pulmonary emphysema.

g. Chronic abscess of lung.

h. Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function or obscure the lung field in the roentgenogram.

i. 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.

j. Empyema, residual sacculation or unhealed sinuses of chest wall following operation for empyema.

k. Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion.

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

m. Multiple cystic disease of the lung or solitary cyst which is large and incapacitating.

n. New growth of breast; history of mastectomy.

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

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

q. Sarcoidosis. See paragraph 2-38.

r. Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.

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

2-27. 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, if severe.

d. Lips, unsightly mutilations of, from wounds, burns, or disease.

e. Ranula, if extensive. For other tumors see paragraphs 2-10 and 2-41.

2-28. Nose

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

a. Allergic manifestations.

(1) Chronic atrophic rhinitis.

(2) Hay fever if severe; and if not controllable by antihistamines or by desensitization, or both.

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

c. Nasal septum, perforation of:

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

(2) If progressive.

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

d. *Sinusitis*, acute.

e. *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 tissues, or symptoms requiring frequent medical attention.

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

2-29. Pharynx, Trachea, Esophagus, and Larynx

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

a. *Esophagus*, organic disease of, such as ulceration, varices, achalasia; peptic esophagitis; if confirmed by appropriate X-ray or esophagosopic examinations.

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

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

d. *Plica dysphonia venricularis*.

e. *Tracheostomy or tracheal fistula*.

2-30. Other Defects and Diseases

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

a. *Aphonia*.

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

c. *Destructive syphilitic disease of the mouth, nose, throat, larynx, or esophagus*. (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

2-31. Neurological Disorders

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

a. *Degenerative disorders*.

(1) Cerebellar and Friedreich's ataxia.

(2) Cerebral arteriosclerosis.

(3) Encephalomyelitis, residuals of, which preclude the satisfactory performance of military duty.

(4) Huntington's chorea.

(5) Multiple sclerosis.

(6) Muscular atrophies and dystrophies of any type.

b. *Miscellaneous*.

(1) Congenital malformations if associated with neurological manifestations and meningocele even if uncomplicated.

(2) Migraine when frequent and incapacitating.

(3) Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause which is of such a nature or degree as to preclude the satisfactory performance of military duty.

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(4) Tremors, spasmodic torticollis, athetosis or other abnormal movements more than mild.

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

d. *Paroxysmal convulsive disorders*, disturbances of consciousness, all forms of psychomotor or temporal lobe epilepsy or history thereof except for seizures associated with toxic states or fever during childhood up to the age of 12.

e. *Peripheral nerve disorder*.

(1) Polyneuritis.

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

(3) Neurofibromatosis.

f. *Spontaneous subarachnoid hemorrhage*, verified history of, unless cause has been surgically corrected.

Section XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

2-32. Psychoses

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

Psychosis or authenticated history of a psychotic illness other than those of a brief duration associated with a toxic or infectious process.

2-33. Psychoneuroses

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

a. *History of a psychoneurotic reaction* which caused—

- (1) Hospitalization.
- (2) Prolonged care by a physician.
- (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 school or work efficiency.

b. *History of a brief psychoneurotic reaction* or nervous disturbance within the preceding 12 months which was sufficiently severe to require medical attention or absence from work or school for a brief period (maximum of 7 days).

2-34. Personality Disorders

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

a. *Character and behavior disorders*, as evidenced by—

(1) Frequent encounters with law enforcement agencies, or antisocial attitudes or behavior which, while not a cause for administrative rejection, are tangible evidence of an impaired characterological capacity to adapt to the military service.

(2) Overt homosexuality or other forms of sexual deviant practices such as exhibitionism, transvestism, voyeurism, etc.

(3) Chronic alcoholism or alcohol addiction.

(4) Drug addiction.

b. *Character and behavior disorders* where it is evident by history and objective examination that the degree of immaturity, instability, personality inadequacy, and 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 symptomatic immaturity reactions* 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) and 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.

Section XVII. SKIN AND CELLULAR TISSUES

2-35. Skin and Cellular Tissues

The causes for rejection for appointment, enlistment, and induction 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 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, occasionally 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 which is chronic and resistant to treatment.

f.1 Elephantiasis or chronic lymphedema.

g. Epidermolysis bullosa; pemphigus.

h. Fungus infections, systemic or superficial types: If extensive and not amenable to treatment.

i. Furunculosis. Extensive, recurrent, or chronic.

j. Hyperhidrosis of hands or feet: Chronic or severe.

k. Ichthyosis. Severe.

l. Leprosy. Any type.

m. Leukemia cutis; mycosis fungoides; Hodgkins' disease.

n. Lichen planus.

o. Lupus erythematosus (acute, subacute, or chronic) or any other dermatosis aggravated by sunlight.

p. Neurofibromatosis (Von Recklinghausen's disease).

q. Nevi or vascular tumors: If extensive, unsightly, or exposed to constant irritation.

r. Psoriasis or a verified history thereof.

s. Radiodermatitis.

t. Scars which are so extensive, deep, or adherent that they may interfere with the wearing of military equipment, or that show a tendency to ulcerate.

u. Scleroderma. Diffuse type.

v. Tuberculosis. See paragraph 2-38.

w. Urticaria. Chronic.

x. Warts, plantar, which have materially interfered with the following of a useful vocation in civilian life.

y. Xanthoma. If disabling or accompanied by hypercholesterolemia or hyperlipemia.

z. Any other chronic skin disorder of a degree or nature which requires frequent outpatient treatment or hospitalization, interferes with the satisfactory performance of duty, or is so disfiguring as to make the individual objectionable in ordinary social relationships.

★*aa. Tattoos on any part of the body* which in the opinion of the examining physician are obscene or so extensive on exposed areas as to be considered unsightly, are administratively disqualified.

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

2-36. Spine and Sacroiliac Joints

(See also para 2-11.)

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

a. Arthritis. See paragraph 2-11a.

b. Complaint of disease or injury of the spine or sacroiliac joints either with or without objective signs and symptoms which have prevented the individual from successfully following a physically active vocation in civilian life. Substantiation or documentation of the com-

plaint without symptoms and objective signs is required.

c. Deviation or curvature of spine from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis, spina bifida occulta, spondylolysis, etc.), if—

(1) Mobility and weight-bearing power is poor.

(2) More than moderate restriction of normal physical activities is required.

(3) Of such a nature as to prevent the individual from following a *physically active vocation* in civilian life.

(4) Of a degree which will interfere with the wearing of a uniform or military equipment.

(5) Symptomatic, associated with positive physical finding(s) demonstrable by X-ray.

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

e. Granulomatous diseases either active or healed.

f. Healed fracture of the spine or pelvic bones with associated symptoms which have prevented

the individual from following a *physically active vocation* in civilian life or which preclude the satisfactory performance of military duty.

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

h. Spondylolysis or spondylolisthesis that is symptomatic or is likely to interfere with performance of duty or is likely to require assignment limitations.

2-37. 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 of rib, sternum, clavicle, scapula, or vertebra.

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

Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

2-38. Systemic Diseases

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

a. Dermatomyositis.

b. Lupus erythematosus: acute, subacute, or chronic.

c. Progressive systemic sclerosis.

d. Reiter's Disease.

e. Sarcoidosis.

f. Scleroderma, diffuse type.

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) (Deleted).

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 paragraph 2-28.

(2) Asthma. See paragraph 2-26b.

(3) Allergic dermatoses. See paragraph 2-35.

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

(5) Bona fide history of moderate or severe generalized (as opposed to local) allergic reaction to insect bites or stings. Bona fide history of

severe generalized reaction to common foods, e.g., milk, eggs, beef, and pork.

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 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 examinee medically unacceptable.

e. Cold injury, residuals of, (example: frostbite, chilblain, immersion foot, or trench foot) such as 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, immuniza-

tions, 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, trichlorethylene, 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 preclude the satisfactory performance of military duty.

Section XX. TUMORS AND MALIGNANT DISEASES

2-40. Benign Tumors

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

a. Any tumor of the—

- (1) Auditory canal, if obstructive.
- (2) Eye or orbit (see also para 2-2a(6)).
- (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 of original lesion.

b. Benign tumors of the abdominal wall if sufficiently large to interfere with military duty.

c. Benign tumors of bone likely to continue to enlarge, be subjected to trauma during military service, or show malignant potential.

★*d. Benign tumors of the thyroid or other struc-*

tures 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.

e. Tongue, benign tumor of, if it interferes with function.

f. Breast, thoracic contents, or chest wall, tumors, of, other than fibromata lipomata, and inclusion or sebaceous cysts which do not interfere with military duty.

g. For tumors of the internal or external female genitalia see paragraph 2-14h.

2-41. Malignant Diseases and Tumors

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

a. Leukemia, acute or chronic.

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- b. *Malignant lymphomata.*
- c. *Malignant tumor of any kind*, at any time, substantiated diagnosis of, even though surgically

removed, confirmed by accepted laboratory procedures, except as noted in paragraph 2-12a(6).

Section XXI. VENEREAL DISEASES

2-42. Venereal Diseases

In general the finding of acute, uncomplicated venereal disease which 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 venereal disease* which has not satisfactorily responded to treatment. The finding of a positive serologic test for syphilis following the adequate treatment of syphilis is not in itself con-

sidered evidence of chronic venereal disease which has not responded to treatment (para 2-39f).

- b. *Complications and permanent residuals* of venereal disease if progressive, of such nature as to interfere with the satisfactory performance of duty, or if subject to aggravation by military service.

- c. *Neurosyphilis.* See paragraph 2-31c.

★Section XXII. VOCATIONAL WAIVERS

2-43. Vocational Waivers

When an individual who fails to meet the medical standards listed in this chapter has demonstrated in the pursuit of his civilian occupation, profession, or avocation that he is likely to be able satisfactorily to perform the duties of a member of the Armed Forces, the medical examiner may

recommend to the Surgeon General of the appropriate service that such an individual be accepted on waivers of medical fitness standards. Such cases shall be considered by the Surgeon General before a final decision is made.

CHAPTER 3

MEDICAL FITNESS STANDARDS FOR RETENTION, PROMOTION AND SEPARATION INCLUDING RETIREMENT

(Short Title: **RETENTION MEDICAL FITNESS STANDARDS**)

Section I. GENERAL

3-1. Scope

This chapter sets forth the various medical conditions and physical defects which normally 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 U.S. Army regardless of component. (See AR 635-40, AR 135-175, NGR 20-6, and other appropriate regulations for administrative procedures for separation for medically unfitting conditions that existed prior to service.)

(2) All enlisted personnel of the U.S. Army regardless of component or duty status. (For those individuals who are found to be medically unfit for entry into service because of an EPTS medical condition or physical defect discovered within the first 4 months of active duty or active duty for training under the Reserve Enlistment Program of 1963, but not medically unfit under this chapter, see paragraph 2-2*b* of this regulation, and AR 635-200.)

★(3) Cadets of the United States Military Academy for retention and their subsequent appointment in the regular Army or entry on active duty in enlisted status for whom the standards of this chapter have been made applicable, pursuant to the provisions of paragraph 2-2*e* of this regulation.

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

(1) Retention of officers, warrant officers and enlisted personnel (regardless of component) 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 (regardless of component) who have been retired except those retired for temporary disability.

3-3. Policies

a. Normally, members with conditions listed in this chapter will be considered unfit by reason of physical disability; 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 must be decided upon the relevant facts and a determination of fitness or unfitness must be made dependent upon the abilities of the member to perform the duties of his office, grade, rank, or rating in such a manner as to reasonably fulfill the purpose of his employment in the military service.

b. The various medical conditions and physical defects which may render a member unfit for military duty by reason of physical disability are not necessarily 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 normally makes an individual unfit because of physical disability if—

(1) The individual is precluded from a reasonable fulfillment of the purpose of his employment in the military service, or

(2) The individual's health or well-being would be compromised if he were to remain in the military service, or

(3) The individual's retention in the military service would prejudice the best interests of the Government.

c. A member will not be declared unfit for military service because of impairments which were known to exist at time of his acceptance for military service, and which have remained essentially the same in degree of severity since acceptance and have not interfered with his 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 (chapter 10, AR 635-40, AR 140-120, and NGR 27) will not necessarily be declared unfit because of physical disability solely because of the defect which caused his special status, when the impairment has remained essentially unchanged and has not interfered with his performance of duty. When his separation or retirement is authorized or required for some other reason, this impairment, like any other, will be evaluated in connection with his processing for separation or retirement.

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 pro-

urement 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.

h. Latent impairments will be accorded appropriate consideration both in determining unfitness because of physical disability and in assessing the degree of disability.

i. Every effort will be made to accurately record the physical condition of each member throughout his Army career. A member undergoing examination and evaluation incident to retirement, however, will be judged on actual existing impairments and disabilities with due consideration for latent impairments. It is important, therefore, that all medical conditions and physical defects which are present, be recorded, no matter how minor they may appear. Performance of duty despite an impairment will not be considered presumptive evidence of physical fitness.

3-4. Disposition of Members Who May be Unfit Because of Physical Disability

a. Members who are believed to be unfit because of physical disability, or who have one of the conditions listed in this chapter, will be processed as prescribed in AR 40-3 and AR 635-40 to determine their eligibility for physical disability benefits under chapter 61, title

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10, United States Code. In certain instances, continuance on active duty despite unfitness because of physical disability may be appropriate as indicated below. 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 be retained on active duty and their disability separation or retirement processing deferred for

the duration of the mobilization or as directed by the Secretary of the Army. During mobilization, those who are 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 do not meet retention medical fitness standards (mobilization medical fitness standards when

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 assignment 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 is being considered for separation or retirement for some other administrative reason, the medical examination discloses a substantial hearing defect. This refers particularly to cases requiring hearing aids and those having hearing levels which may be rateable at 30 to 40 percent or more in accordance with the Veterans Administration Schedule for Rating Disabilities. It should be noted that the decibel levels used in the VASRD are without hearing aids, and are related to American Standards Association calibrated testing equipment. Tests performed on International Standards Organization calibrated equipment must be converted to the ASA standard before arriving at a decision regarding the referral of a member for physical disability evaluation under this paragraph. It should be further noted that past performance of duty does not, per se, preclude separation or retirement because of physical disability caused by a hearing defect.

c. Processing of such individuals will be in accordance with AR 40-3.

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 ma-

lignant 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 appendix IV.

(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.* Pronation or supination to the first quarter of the normal arc.

c. Dislocated 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 appendix IV.

(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 recurrent incapacity for prolonged periods. For arthritis due to gonococcal or tuberculous infection see paragraphs 3-35h(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.

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. 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 criterial 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) Visual acuity which cannot be corrected to at least 20/40 in the better eye, or

(2) Visual acuity in the poorer eye has been reduced to light perception or less, or

(3) An eye has been enucleated.

f. Visual field. Bilateral concentric construction to less than 20°.

Section IX. GENITOURINARY SYSTEM

3-17. Genitourinary System

a. Cystitis. When complications or residuals of 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 if 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 arti-

ficial. 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

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.

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 paragraphs 2-9, 2-10, 2-11, and 4-23, plus *Limitation of motion*.

a. Classes 1, 1A and 3: Less than full strength and range of motion of all joints.

b. Class 2: Any limitation of motion of any joint which might compromise flying safety.

Section VIII. EYES AND VISION

4-11. Eyes

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-12, plus the following:

- a. Asthenopia of any degree.*
- b. Chorioretinitis* or substantiated history thereof.
- c. Coloboma* of the choroid or iris.
- d. Epiphora.*
- e. Inflammation of the ureal tract;* acute, chronic, or recurrent.
- 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.

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, or
 - (b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set.

(c) (Deleted).

(2) *Depth perception:*

(a) Any error in lines B, C, or D when using the Machine 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) *Field of vision:*

(a) Any demonstrable scotoma, other than physiologic.

(b) Contraction of the field for form of 15° or more in any meridian.

(5) *Near visual acuity,* uncorrected, less than 20/20 (J-1) in each eye.

(6) *Night vision:* Failure to pass test when indicated by history of night blindness.

(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 six cardinal directions.

(b) Esophoria greater than 10 prism diopters.

(c) Exophoria greater than 5 prism diopters.

(d) Hyperphoria greater than 1 prism diopter.

(c) Heterotropia, any degree.

(8) *Power of accommodation* of 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.

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 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 or not correctable 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.

c. *Class 2*. Same as Class 1 except as listed below:

(1) *Color vision*:

(a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set (Federal stock No. 6515-388-6606), or

(b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set (Federal stock No. 6515-388-6606), or

(c) Failure to pass the Farnsworth Lantern Test when used in lieu of (a) or (b) above.

★(2) *Distant visual acuity*:

(a) *Control tower operators*: Uncorrected that is worse than 20/100 in either eye or such acceptable uncorrected vision that fails to correct to 20/20 in each eye.

(b) (Deleted).

(c) *Pilots*: Uncorrected less than 20/100 in each eye or not correctable to 20/20 in each eye.

(3) *Field of vision*. Scotoma, other than physiological unless the pathologic process is healed and which will in no way interfere with flying efficiency or the well-being of the individual.

(4) *Near visual acuity*. Uncorrected less than 20/100 (J-16) in each eye or not correctable to 20/20 in each eye.

(5) *Ocular motility*:

(a) Hyperphoria greater than 1.5 prism.

(b) Failure of the Red Lens Test (suppression or diplopia within 20 inches from the center of the screen in any of the six cardinal directions) until a complete evaluation by a certified ophthalmologist has been forwarded to The Surgeon General for review.

(6) *Refractive error*: No maximum limits prescribed.

d. *Class 3*:

(1) *Color vision*: Same as Class 2, a(1) above.

(2) *Distant visual acuity*: Uncorrected, less than 20/200 in each eye, not correctable to 20/20 in each eye.

(3) *Near visual acuity, field of vision, night vision, depth perception, power of accommodation, ocular motility*: 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. Class 1 and 1A. Substantiated history of bilateral renal calculi or of repeated attacks of renal or ureteral colic. Examinees with a history of a single unilateral attack are acceptable, provided—

- (1) Excretory urography reveals no congenital or acquired anomaly.
- (2) Renal function is normal.
- (3) The calculus has been passed and the

X-ray shows no evidence of concretion in the kidney, ureter, or bladder.

b. Classes 2 and 3. A history of renal calculus, unless—

- (1) Excretory urography reveals no congenital or acquired anomaly.
- (2) Renal function is normal.
- (3) The calculus has been passed and the X-ray shows no evidence of concretion in the kidney, ureter, or bladder.

Section X. HEAD AND NECK

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; facial paralysis.

Section XI. HEART AND VASCULAR SYSTEM

4-15. Heart and Vascular System

The causes for 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 atrial tachycardia, nodal tachycardia, atrial flutter, and atrial fibrillation.

c. A history of paroxysmal ventricular tachycardia.

d. A history of rheumatic fever, or documented manifestation suggestive of rheumatic fever within the preceding 5 years.

e. Transverse diameter of heart 15 percent or more greater than predicted by appropriate tables.

f. Blood pressure below 90 systolic or 60 diastolic.

g. Unsatisfactory orthostatic tolerance test.

h. Electrocardiographic.

(1) Borderline ECG findings until reviewed by The Surgeon General.

(2) Left bundle branch block.

(3) Persistent premature contractions, except in rated personnel when unassociated with significant heart disease or recurrent tachycardia.

(4) Right bundle branch block unless cardiac evaluation reveals the absence of cardiac disease and that the block is presumably congenital.

(5) Short P-R interval and prolonged QRS time (Wolff-Parkinson-White syndrome) or other short P-R interval syndromes predisposing to paroxysmal arrhythmias. In cases involving Class II or Class III examinations, a complete cardiac evaluation including ECG's will be forwarded to The Surgeon General for review.

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.

b. *Class 2, Air Traffic Control, male.* Height below 60 inches or over 76 inches.

c. *Class 2, Air Traffic Control female.* Height below 60 inches or over 72 inches.

d. *Class 3:*

(1) *Female.* Height below 60 inches or over 72 inches.

(2) *Male.* Height below 62 inches or over 76 inches.

4-17. Weight

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are—

a. Weight for males which does not fall

within the limits prescribed in table III, appendix III.

b. Weight for females which does not fall within the limits prescribed in table II, appendix III except that maximum weight may not exceed 180 pounds.

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 is within the maximum shown in table III, appendix III, he will be found medically unfit for any flying duty (Classes 1, 1A, 2 and 3) when the medical examiner considers that the excess weight, in relationship to the bony structure and musculature, would adversely affect flying efficiency or endanger the individual's well-being if permitted to continue in flying status.

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 the predicted vital capacity (app. VI).

(c) With a value of less than 75 percent of exhaled predicted vital capacity in 1 second (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) *Class 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, normal pulmonary function, no additional lung pathology or other contra-indication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

★d. *Pulmonary tuberculosis and tuberculous pleurisy with effusion:*

(1) *Classes 1 and 1A.* See paragraph 2-25.

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(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.

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 over a radio communications system.

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 (unless mild and functionally asymptomatic).

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.

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.

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.

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★ CHAPTER 5

MEDICAL FITNESS STANDARDS FOR ADMISSION TO U.S. MILITARY ACADEMY (Short Title: USMA MEDICAL FITNESS STANDARDS)

Section I. GENERAL

5-1. Scope

This chapter sets forth medical conditions and physical defects which are causes for rejection for admission to the U.S. Military Academy.

5-2. Applicability

The causes for rejection for admission to the U.S. Military Academy are all of the causes listed

in chapter 2, plus all of the causes listed in this chapter. These standards and the medical fitness standards contained in chapter 2, as further restricted herein, apply to—

a. *All candidates and prospective candidates for the Military Academy.*

b. *All ex-cadets under consideration for readmission as a Cadet of the U.S. Military Academy.*

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

5-3. Abdomen and Gastrointestinal System

The causes of medical unfitness for USMA are

the causes listed in paragraph 2-3 plus the following.

Hernia of any variety.

Section III. BLOOD AND BLOOD-FORMING TISSUE DISEASES

5-4. Blood and Blood-Forming Tissue Diseases

The causes of medical unfitness for USMA are the causes listed in paragraph 2-4.

Section IV. DENTAL

5-5. Dental

The causes of medical unfitness for USMA are—

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

b. *Jaw:* Relationship between the mandible and maxilla of such nature as to preclude satisfactory prosthodontic replacements should it become necessary to remove any or all of the remaining natural teeth.

c. *Prosthodontic appliances:*

(1) Appliances below generally accepted

standards of design, construction, and tissue adaptation.

(2) Lower appliance which is not retained or adequately stabilized by sufficient serviceable natural teeth.

d. *Teeth:*

(1) Carious natural teeth which are unfilled or improperly filled.

(2) Grossly disfiguring spacing of existing anterior teeth.

(3) Insufficient upper and lower serviceable anterior and posterior natural or artificial teeth functionally opposed to permit mastication of normal diet.

Section V. EARS AND HEARING

5-6. Ears

The causes of medical unfitness for USMA are the causes listed in paragraph 2-6, plus the following:

a. *Abnormalities* which are disfiguring or incapacitating.

b. *Disease*, acute or chronic.

c. *Perforation of the tympanic membrane*, regardless of etiology.

5-7. Hearing

The causes of medical unfitness for USMA are—
Hearing acuity level by audiometric testing (re-

gardless of conversational or whispered voice
hearing acuity) greater than that prescribed in
table III, appendix II.

Section VI. ENDOCRINE AND METABOLIC DISORDERS

5-8. Endocrine and Metabolic Disorders

The causes of medical unfitness for USMA are the causes listed in paragraph 2-8.

Section VII. EXTREMITIES

5-9. Upper Extremities

The causes of medical unfitness for USMA are
the causes listed in paragraphs 2-9 and 2-11, plus
the following:

★ *a. Absence of one phalanx of any finger in
association with the absence of the little finger of the
same hand.*

*b. Any deformity or limitation of motion which
precludes the proper accomplishment of the hand
salute or manual of arms, which detracts from
smart military bearing or appearance, or which
would interfere with daily participation in a rig-
orous physical training or athletic program.*

5-10. Lower Extremities

The causes of medical unfitness for USMA are

the causes listed in paragraphs 2-10 and 2-11, plus
the following:

*a. Any deformity or limitation of motion which
interferes with the proper accomplishment of close
order drill, which detracts from a smart military
bearing or appearance, or which would interfere
with daily participation in a rigorous physical
training or athletic program.*

*b. Flatfoot, symptomatic, or with marked bulg-
ing of the inner border of the astragalus.*

*c. Pes cavus with clawing of the toes and cal-
luses beneath the metatarsal heads.*

*d. Shortening of a lower extremity which requires
a lift or when there is any perceptible limp.*

Section VIII. EYES AND VISION

5-11. Eyes

The causes of medical unfitness for USMA are
the causes listed in paragraph 2-12, plus the
following:

*a. Any acute or chronic disease of the eye or
adnexa.*

b. Any disfiguring or incapacitating abnormality.

c. Ocular mobility and motility.

(1) Esophoria of over 15 prism diopters.

(2) Exophoria of over 10 prism diopters.

(3) Hyperphoria of over 2 prism diopters.

(4) Strabismus of any degree.

5-12. Vision

The causes of medical unfitness for USMA are

the causes listed in paragraph 2-13, plus the
following:

a. Color blindness: 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.

b. Visual acuity: Distant visual acuity which
does not correct to at least 20/20 in each eye.

c. Refractive error:

(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.

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factorily 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 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

Uncorrected 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 medically unfit. However, 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 par. 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 (app. IV). Range of motion limitations tempo-

rarily not meeting these standards, because of disease or injury or remediable 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

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.
- (3) *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 (app. IV). 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 pars. 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 pars. 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 of 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 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 congenital. Confirmed.

g. Osteitis deformans (Paget's Disease). Involvement in single or multiple bones with resultant deformities or symptoms severely interfering with function.

h. Osteoarthropathy, hypertrophic, second-

ary: 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.

g. Visual field. Constricted to less than 20° in diameter.

Section IX. GENITOURINARY SYSTEM

6-15. Genitourinary System

(See also para 6-16.)

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 avoided 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.

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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 U.S. Military Academy.

7-20. 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, 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.

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 trait or sickle cell disease.

c. *Dental.* Paragraph 2-5.

d. *Ears and hearing.*

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

★(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.

(4) Color vision. Failure to identify red and/or green as projected by the Ophthalmological Projector (Federal Stock No. 6515-388-3600) or Armed Forces Vision Tester (Federal Stock No. 6515-299-8084) equipped with Bausch and Lomb Orthorater, Slide No. 71-21-21. (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 if discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2-27, 2-28, 2-29 and 2-30.

p. Neurological disorders.

(1) Paragraph 2-31.

(2) Active disease of the nervous system of any type.

(3) Craniocerebral injury (para 4-23a (7)).

q. Psychoses psychoneuroses, and personality disorders.

(1) Paragraphs 2-32, 2-33, and 2-34.

(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 2-35.

s. Spine, scapulae, and sacroiliac joints.

(1) Paragraphs 2-36, 2-37, and *e* above.

(2) Scoliosis: lateral deviation of tips of vertebral spinous processes more than one 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.

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t. Systemic diseases and miscellaneous conditions and defects.

(1) Paragraphs 2-38 and 2-39.

(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. Paragraphs 2-40 and 2-41.

v. Venereal 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.

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**Section V. MEDICAL FITNESS STANDARDS FOR ENLISTED MILITARY
OCCUPATIONAL SPECIALTIES**

**7-8. 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.

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

considered on an individual basis for an administrative waiver by Headquarters, Department of the Army during the processing of their applications.

b. Individuals being considered for appointment in the Regular Army in Armor, Artillery, or Infantry who are not more than 2 inches below the minimum height requirement of 66 inches *will automatically* be considered for an administrative waiver by Headquarters, Department of the Army during the processing of their applications provided they have outstanding abilities, military records, or educational qualifications.

★7-14. Height—United States Military Academy

(See para 5-16.)

The following applies to all male candidates to the United States Military Academy:

Candidates for admission to the United States Military Academy who are over the maximum height of 80 inches or below the minimum height of 66 inches will automatically be recommended by The Surgeon General 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 qualification, have an outstanding military record, or have demonstrated outstanding abilities.

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)

7-17. 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 7-9d.

b. Inability to distinguish and identify without confusion the color of an object, substance,

7-15. Vision—Officer Assignment to Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps

(See para 2-12 and 2-13.)

Individuals being considered for officer assignment to Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps must meet the following standards: Uncorrected distant visual acuity of any degree that corrects to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error.

7-16. Weight—Enlistment in WAC for Student Nurse Program and Student Dietician Program and Appointment Therefrom

The medical fitness standards for initial selection as members of the Women's Army Corps for Training under the Army Student Nurse and the Army Student Dietician Programs, and for commissioning from these programs are set forth in chapter 2 except that the maximum weight standards set forth in table II, appendix III may be exceeded by 10 percent.

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 (for individuals of susceptible groups).

- (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

7-18. Standards

When so directed in special procurement programs prescribed by the Department of the Army, active duty officers and enlisted men possessing current valid FAA private pilot certificates or higher certificates may be medically qualified for initial Army aviation flight training under the following modified medical fitness standards. (Class 1A medical fitness standards for flying duty as prescribed in chapter 4) except—

a. *Vision*—Uncorrected distant visual acuity no worse than 20/100 in each eye. Distant vis-

ual acuity must correct to 20/20 in each eye. Uncorrected near visual acuity no worse than 20/100 in each eye, which must correct to 20/20 in each eye.

b. *Refractive error*.

(1) *Astigmatism*: Not more than 1.00 diopter.

(2) *Hyperopia*: Not more than 1.75 diopters under age 35 and not more than 2.00 diopters over age 35 in any meridian.

(3) *Myopia*: Not more than 1.25 diopters in any meridian regardless of age.

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★CHAPTER 8

**MEDICAL FITNESS STANDARDS FOR PHYSICIANS, DENTISTS,
AND ALLIED MEDICAL SPECIALISTS**

(Short Title: **MEDICAL SPECIALISTS MEDICAL FITNESS STANDARDS**)

Section I. GENERAL

8-1. Scope

This chapter sets forth the minimum level of medical fitness standards for physicians, dentists, and allied medical specialists.

8-2. Applicability

a. These standards apply only in evaluating physicians, dentists, or allied medical specialists for—

(1) Induction.

(2) Appointment in other than the regular component of the Armed Forces.

(3) Entry on active duty or active duty for training as an officer or an enlisted member of a component of the Armed Forces other than regular.

b. These standards are not applicable to an individual who is over 35 years of age or who is otherwise exempt from training and service under the Military Selective Service Act.

8-3. Department of Defense Policy

The policy of the Department of Defense regarding the medical fitness criteria is that—

a. Physicians, dentists, and allied medical specialists are considered to be potentially ac-

ceptable for military service provided they can reasonably be expected to be productive in the Armed Forces.

b. Physicians, dentists, and allied medical specialists with static impairments and those with chronic progressive or recurrent diseases, if asymptomatic or relatively so, are considered acceptable for military service.

8-4. Questionable Cases

Questionable cases involving the diagnoses listed below will be referred in accordance with current procedures to The Surgeon General, ATTN: MEDPS-SP, Department of the Army, for an opinion of acceptability prior to qualification.

a. *Congenital abnormalities of heart and great vessels.*

b. *Hernia (only those cases considered irre-*

mediable).

c. *Peptic ulcer.*

d. *Psychoneuroses and psychoses.*

e. *Tuberculosis.*

f. *Nephrolithiasis.*

Section II. MEDICAL FITNESS STANDARDS

8-5. Basic Medical Fitness Standards

a. The nature of the duties expected of physicians, dentists and allied medical specialists is such, in general, that although they may have physical defects or medical conditions which would ordinarily be cause for rejection for original entry into the military service,

they may be expected to perform appropriate military duties in their specialities.

b. The causes of medical unfitness for the purpose shown in paragraph 8-2 are the causes for rejection listed in chapter 3, plus all of the causes listed in this chapter.

8-6. Abdomen and Gastrointestinal System

The causes of medical unfitness for physicians, dentists and allied medical specialists are—

- a. Paragraphs 3-5 and 3-6.
- b. *Amebiasis*: A history of amebiasis when active hepatic involvement is present.
- c. *Anal fistula* with extensive multiple sinus tracts.
- d. *Chronic cholecystitis or cholelithiasis* if disabling for civilian practice.
- e. *Liver disease*: A history of liver disease when presence of liver disease is manifested by hepatomegaly or abnormal liver function studies. If disease is considered temporary: Deferment for reexamination at a later date.

f. *Peptic ulcer*: A history of peptic ulcer complicated by obstruction, verified history of perforation, or recurrent hemorrhage is disqualifying. An individual with X-ray evidence of an active ulcer will be deferred for reexamination at a later date. A history of peptic ulcer or a healed ulcer, with scarring but without a niche or crater as demonstrated by X-ray, is acceptable.

g. *Splenectomy*: A history of splenectomy except when the surgery was for trauma, surgery unrelated to disease of the spleen, hereditary spherocytosis, or disease involving the spleen where splenectomy was followed by correction of the condition for a period of at least 2 years.

h. *Ulcerative colitis*: Confirmed by proctosigmoidoscopic or X-ray findings.

8-7. Blood and Blood-Forming Tissue Diseases

The causes of medical unfitness for physicians, dentists, and allied medical specialists are the same as those listed in paragraph 3-7, except that splenomegaly is not disqualifying per se, however, its underlying causes may be disqualifying.

8-8. Dental

The causes of medical unfitness for physicians, dentists, and allied medical specialists are the same as those listed in paragraph 3-8.

8-9. Ears and Hearing

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraph 3-9.

b. *Auditory acuity*: Hearing which cannot be improved in one ear with a hearing aid to an average hearing level of 20 decibels or less in the speech reception range. Unilateral deafness is not disqualifying.

c. *Meniere's syndrome*: An individual who suffers Meniere's syndrome is disqualified when he has severe recurring attacks which cannot be controlled by treatment or requires hospitalization of sufficient frequency to interfere materially with civilian practice.

d. *Otitis media*, if chronic, suppurative, resistant to treatment, and necessitating hospitalization of sufficient frequency to interfere materially with civilian practice.

8-10. Endocrine and Metabolic Diseases

The causes of medical unfitness for physicians, dentists, and allied medical specialists are the causes listed in paragraph 3-11.

8-11. Extremities

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraphs 3-12, 3-13, 3-14, and 8-22.

b. *Amputation of leg or thigh* if suitable prosthesis is not available or if the use of a cane or crutch is required.

c. *Weight bearing joints*: Inability to bear weight. Instability of a weight bearing joint or any disease processes of weight bearing joints requiring use of a cane or crutch.

d. *Congenital or acquired deformities* of the feet when shoes cannot be worn or if the individual is required to use a cane or crutches.

e. *Dislocated semilunar cartilage* when disabling for civilian practice.

f. *Loss of fingers or toes*: Qualification will be based upon the individual's ability to perform civilian practice in his specialty.

g. *Osteomyelitis*: Where there has been X-ray or other evidence of bone infection, drainage, or disturbance of weight bearing function in the preceding 12 months.

h. *Paralysis secondary to poliomyelitis* when suitable brace cannot be worn or if cane or crutches are required for the lower extremities. Mobility of the extremities should be adequate to assure useful function thereof and a military appearance.

i. Old ununited or malunited fractures, involving weight-bearing bones when there is sufficient shortening or deformity to prevent the performance of military duty.

8-12. Eyes and Vision

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. The causes listed in paragraphs 3-15 and 3-16, except as modified below.

b. Absence of an eye or when visual acuity has been reduced to light perception only when there is active eye disease in the other eye or the vision in the other eye does not correct to at least 20/30.

8-13. Genitourinary System

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. The causes listed in paragraphs 3-17 and 3-18.

b. Chronic prostatitis or hypertrophy of prostate, with evidence of urinary retention.

c. Kidney.

(1) Absence of one kidney where there is progressive disease or impairment of function in the remaining kidney.

(2) Cystic (polycystic kidney). Asymptomatic, history of.

d. Nephritis. A history of nephritis, with residuals such as hypertension or abnormal urinary or blood findings.

e. Nephrolithiasis. (Rescinded.)

8-14. Head and Neck

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraphs 3-19 and 3-20.

b. Skull defects are acceptable unless residual signs and symptoms are incapacitating in civilian practice.

8-15. Heart and Vascular System

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraphs 3-21, 3-22, and 3-23.

b. Auricular fibrillation. Paroxysmal auricular fibrillation with evidence of organic heart disease, or persistent auricular fibrillation from any cause.

c. Auriculoventricular block, when due to organic heart disease.

d. Coarctation of the aorta and other significant congenital anomalies of the vascular system unless satisfactorily treated by surgical correction.

e. Hypertension. Blood pressure frequently elevated to 200/120 or more (which returns to normal limits with rest and sedatives) or a persistent diastolic pressure over 110-mm mercury even though cerebral, renal, cardiac, and retinal findings are normal.

f. Phlebitis. Recurrent phlebitis, other than mild. Residuals of phlebitis, such as persistent edema, dermatitis, ulceration, or claudication, which interfere materially with civilian practice, also make the individual medically unfit.

g. Valvular heart disease. Cardiac insufficiency at a functional capacity level of Class IIC or worse, American Heart Association (app VII).

h. Varicose veins associated with ulceration of the skin, symptomatic edema, or recurring incapacitating dermatitis.

i. Rheumatic fever.

(1) Residuals involving the heart at a functional capacity level of Class IIC or worse, American Heart Association (app VII).

(2) Verified history of recurrent attacks, cardiac involvement, or subacute bacterial endocarditis within the past 2 years.

8-16. Height, Weight, and Body Build

(Rescinded.)

8-17. Lungs and Chest Wall

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraphs 3-24 and 3-25.

b. Bronchial asthma. Associated with emphysema of sufficient degree to interfere with performance of duty, or with frequent attacks controlled only by continuous systemic corticosteroid therapy, or with frequent attacks which are not controlled by oral medication.

c. Bronchiectasis and emphysema. When outpatient treatment or hospitalization is of such frequency as to interfere materially with civilian practice. Bronchiectasis confined to one lobe is usually acceptable; however, the saccular, systic, and dry types, involving more than one lobe, make the individual medically unfit.

d. Chronic bronchitis complicated by disabling emphysema or requiring outpatient treatment

or hospitalization of such frequency as to interfere materially with civilian practice.

e. Pleurisy with effusion. An individual with serofibrinous pleurisy due to known or proven acute or inflammatory conditions may be considered as acceptable for military service if there has been no recurrence for 1 year. If the effusion exceeds 100 cc, is not transient in character, and does not appear to be secondary to pneumonia or other demonstrable non-tuberculous disease, it will be considered to be a manifestation of active tuberculosis and will be disqualifying until the disease has become inactive and remained so for 5 years.

f. Sarcoidosis. Symptomatic pulmonary sarcoidosis which has not responded promptly to therapy or which is complicated by residual pulmonary fibrosis.

g. Spontaneous pneumothorax with recovery is acceptable.

★*h. Tuberculosis.*

(1) Tuberculosis, active in any form or location. A positive skin test without other evidence of active disease is not disqualifying. Individuals taking prophylactic chemotherapy because of recent skin test conversion are not disqualified.

(2) A history of active tuberculosis within the past two years which has not been treated with adequate drug therapy.

(3) A history of active tuberculosis within one year which has been or continues to be treated with drug therapy. A person in whom tuberculosis has been inactive for more than one year and who may reasonably be expected to be physically capable of performing satisfactory professional and associated military duties is acceptable even though on active drug therapy.

(4) Tuberculosis which has caused pulmonary or other organ function impairment

which would preclude satisfactory performance of duty.

8-18. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraph 3-27.

b. Polyps or mucoceles, when moderate to severe, suppurative, and unresponsive to treatment.

c. Chronic sinusitis, when moderate to severe, suppurative, and unresponsive to treatment.

8-19. Neurological Disorders

The causes of medical unfitness for physicians, dentists, and allied medical specialists are the causes listed in paragraph 3-28.

8-20. Psychoses, Psychoneuroses, and Personality Disorders

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraphs 3-29, 3-30, 3-31, and 3-32.

b. Psychoneurosis when severe and incapacitating for practice in civilian life. An individual who is undergoing continuous active neuropsychiatric therapy should be deferred and reconsidered at a later date. Neuropsychiatric consultation, in addition to Standard Forms 88 and 89 on an individual who is or claims to be a sexual deviate will be referred to The Surgeon General, ATTN: MEDPS-SP, Department of the Army, for an opinion of acceptability prior to qualification.

c. Psychosis of organic or functional etiology except if in complete remission for 2 years or more. Neuropsychiatric consultation, in addition to Standard Forms 88 and 89, will be sent to The Surgeon General, ATTN: MEDPS-SP,

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★CHAPTER 9 PHYSICAL PROFILING

Section I. GENERAL

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 preinduction medical examination pursuant to the Universal Military Training and Service Act (50 USC, Supplement IV, appendix 454, as amended).

b. Applicants for enlistment or appointment in the United States Army.

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 Armed Forces examining 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 functional ability of an individual to perform military duties. In relation to this performance, 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 his 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. In developing the system, the human functions have been considered under six factors. For ease in accomplishing and applying the profile system, 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 *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 or stamina and reflects organic defects or diseases which affect general physical capacity and which do not fall under other factors of this system. 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 organs; 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 functional use of 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 functional use of 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 (physical and mental) fitness and, consequently, he is medically fit for any military assignment.

★(2) A physical profile 2 under any or all factors indicates that an individual meets procurement (entry) standards, but possesses some medical condition of physical defect which may impose some limitations on initial MOS classification (see AR 611-201) and assignment. As an exception to the provisions of paragraph 9-5, individuals with numerical designator 2 under one or more factors who are determined by a medical board to require an assignment limitation will be awarded specific assignment limitations under Code U.

(3) A profile containing one or more numerical designation "3" signifies that the individual has medical condition(s) or physical defect(s) which requires certain restrictions in assignment within which he is physically capable of performing full military duty. Such individuals are not acceptable under procurement (entry) standards in time of peace, but may be acceptable in time of partial or total mobilization. They meet the retention standards, while in service, but should receive assignments commensurate with their functional capability..

(4) A profile serial containing one or more numerical designation "4", indicates that the individual has a medical condition or physical defect which is below the level of medical fitness for retention (continuance) in the mili-

tary service during peacetime. See Code designations "V" and "W" (para 9-5).

d. Anatomical defects or pathological conditions will not of themselves form the sole basis of classification. Since minor physical defects or medical conditions have different values in relation to performance of duties they will not automatically necessitate assignment limitations. While these defects must be given consideration in accomplishing the profile, it is important to consider function and prognosis, especially regarding the possibility of aggravation. In this connection, a close relationship must exist between medical officers and personnel management officers. The determination of assignment is an administrative procedure. The medical officer's report assists the personnel management officer in assessing the individual's medical capability to fill duty positions. It is, therefore, the responsibility of the personnel management officer, based on his knowledge of the individual's profile, to determine whether the individual may be employed in certain duty positions. Appendix VIII contains a Physical Profile Functional Capacity Guide.

9-4. Modifier to Serial

To make the profile serial more informative, the modifier "R" or "T" 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. *"R"—Remediable.* This modifier indicates that the condition necessitating numerical designation "3" or "4" is considered remediable, the correction or treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. An individual on active duty with an "R" 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 an "R" modifier for more than 12 months without positive action being taken either to correct the defect or to effect other appropriate disposition. As a general rule the medical officer initiating the "R" modifier will initiate appropriate arrangements for the necessary correction or treatment of the remediable condition.

b. "T"—*Temporary*. This modifier indicates that the condition necessitating a numerical designation "3" or "4" is temporary and that upon further healing or convalescence a higher physical capacity will prevail. An individual on active duty whose physical profile contains a "T" modifier will be medically evaluated at least once every 3 months with a view to revising the profile. In no case will such a modifier be terminated without concurrence of a medical officer. Individuals in military status will not carry a "T" modifier for more than 12 months without appearance before a medical board.

c. *Records*. Whenever a temporary or remediable condition is recorded on a form where each PULHES factor has a blocked space provided for entry of its numerical designation, the modifier

"T" or "R" will be entered with the appropriate numerical designation in the pertinent space.

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 coded 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 records and morning reports in accordance with AR 640-203 and AR 335-60. 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 with a "2" as the lowest numerical designator. CODE B.....	No significant assignment limitation. Combat fit. May have minor impairment under one or more PULHES factors which disqualify for certain critical 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" as the lowest numerical designator in any factor. CODE C.....	Meets retention standards. Possesses impairment of function limiting assignment.	Vascular insufficiency, symptomatic flat-foot, low back pathology, arthritis of low back or lower extremities.
CODE D.....	No crawling, stooping, running, jumping, prolonged standing, or marching.	Organic cardiac disease, pulmonary insufficiency, hypertension more than mild.
CODE E.....	No strenuous physical activity.....	Endocrine disorders—Recent or repeated peptic ulcer activity—Chronic gastrointestinal disease requiring dietary management.
CODE F.....	No assignment to units requiring continued consumption of combat rations.	Individuals who require continued medical supervision or periodic followup: Cases of established pathology likely to require frequent out-patient care or hospitalization. Used only if other codes do not apply.
CODE G.....	No assignment to isolated areas where definitive medical care is not available. (MAAG—Military Missions, etc.).	Arthritis of the neck or joints of the upper extremities with restricted motion. Cervical disk disease, recurrent shoulder dislocation.
CODE G.....	No assignment requiring prolonged handling of heavy materials including weapons. No overhead work, no pull-ups or push-ups.	

	<i>Description/assignment limitation</i>	<i>Medical criteria</i>
CODE H.....	No assignment where sudden loss of consciousness would be dangerous to self or others, such as work on scaffolding, handling dangerous explosives, driving of military vehicles, work near moving machinery.	Epileptic disorders (cerebral dysrhythmia) of any type; other disorders producing syncopal attacks or severe vertigo, such as Meniere's syndrome.
CODE J.....	No assignment involving habitual or frequent exposure to loud noises or firing of weapons. (Not to include firing for POR qualification.)	Advanced hearing loss, susceptibility to acoustic trauma, persistent severe tinnitus.
CODE L.....	No assignment which requires prolonged or repeated exposure to extreme cold.	Documented history of cold injury, vascular insufficiency, collagen disease with vascular or skin manifestations.
CODE M.....	No assignment requiring prolonged or repeated exposure to high environmental temperature.	History of heat stroke, history of skin malignancy or other chronic skin diseases which are aggravated by sunlight or high environmental temperatures.
CODE N.....	No continuous wearing of combat type boots.	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.	Established allergy to wool, moderate.
CODE U.....	Limitation not otherwise described; to be considered individually.	Any significant functional impairment requiring 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..... *Department of Army Flag.* 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 paragraph 11b, AR 140-120, AR 616-41, 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 his case.

Chapter 3, AR 40-501.

*Description/Assignment Limitation**Medical Criteria*

CODE W ----- *Waiver.* 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 paragraph 8-4, 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 with close proximity to a medical facility capable of handling his case.

Chapters 3, 6, and 8, AR 40-501.

9-6. Profiling Officer

The commander of a medical treatment facility will designate one or more medical officer(s) as profiling officer(s). He will assure that officers so designated are thoroughly familiar with profiling procedures as set forth in this chapter. The senior medical officer on duty at an Armed Forces examining station will be designated as the profiling officer for that station.

★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.

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 4 (Enlistment Record—Armed Forces of the United States), in the items provided on these forms for this purpose. Modifiers "R" and "T" will be entered with the factor involved. When numerical designators of "3" and "4" or modifiers "R," "T" are entered on the profile serial, a brief description of the defect expressed in

nontechnical language will always be recorded in item 74, Standard Form 88, in addition to the exact diagnosis required to be reported in summarizing the defects under item 74. The appropriate diagnosis code (AR 40-401) corresponding to the exact diagnosis will be entered in parentheses *after* the nontechnical description, e.g., nervousness (3100). 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 the Standard Form 88, proper reference will be made in that item and an additional sheet of paper will be added to the Standard Form 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 these chapters. Profiling will be accomplished under provisions of this chapter, whenever such individuals are found to meet the medical procurement standards obtaining at the time of examination.

d. In order to properly categorize persons examined at the Armed Forces Examining and Entrance Stations with respect to their organic functional ability, the following physical designation will be utilized (item 77, SF 88).

(1) Physical category "A" will be checked when an examinee's physical profile reflects a numerical designation of "1" under each of the PULHES factors. In effect this physical cate-

gory identifies individuals who meet peacetime procurement standards and who also possess all the functional capabilities to be trained in any MOS. (This physical category is identified by the Selective Service System by the evaluation symbol "X".)

(2) Physical category "B" will be checked when an examinee's physical profile reflects a numerical designation "2" or the letter "T" under any of the PULHES factors and when the examinee meets standards for enlistment or induction during peacetime (chap 2). In effect this physical category will identify individuals who meet peacetime procurement standards but are lacking at least one of the functional capabilities required by many MOS. (This category is also identified by the Selective Service System by the evaluation symbol "X".)

(3) Physical category "C" will be checked when there is a profile containing one or more numerical designation "3" under the PULHES factors. This indicates the examinee *does not* meet peacetime procurement standards (chap 2), but does meet the mobilization standards (chap 6). (This category is identified by the Selective Service System by the evaluation symbol "Y".)

(4) Category "E" will be checked when the examinee has a profile serial containing one or more numerical designation "4" under any or all of the PULHES factors. He does not meet medical fitness standards for military service during peacetime (chap 2) or mobilization (chap 6). (This category is identified by the Selective Service System by the evaluation symbol "Z" or IV-F.)

9-8. Revision and Verification of Physical Profile

a. The physical profile may be verified or revised by a medical profiling officer, by the commander of the medical treatment facility, or by a medical board as provided for in AR 40-3.

b. Each individual whose functional capacity has changed will be interviewed as indicated below and, if necessary, examined by a medical profiling officer to ascertain whether or not

the recorded physical profile serial is a true reflection of his actual functional capacity. If the individual's unit commander or a personnel management officer is available, he or they should assist the profiling officer, when requested, in verifying and/or recommending revision of the profile. 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 his ability to perform duty. Except as indicated in *e* and *h* below, permanent revision of profile from or to a numerical designator "3" or "4" will be accomplished by a medical board when, in the opinion of the profiling officer, the functional capacity of the individual has changed to such an extent that it permanently alters his functional ability to perform duty. Whenever a medical board is held for the sole purpose of permanently revising the physical profile to or from a numerical designator "3" the Medical Condition, Physical Profile Record (DA Form 3349) (fig. 9-1) will be used in lieu of the Medical Board Proceedings (DA Form 8-118). Medical Board officers and the approving authority will complete the appropriate items on reverse of DA Form 3349. When the profile serial is revised, the revision will be submitted to the individual's unit commander on a DA Form 3349. This will permit proper coding by personnel officers as outlined in paragraph 9-5 and reclassification and assignment in keeping with the individual's physical and mental qualifications. If, in the opinion of the medical profiling officer, the functional capacity of the individual has not been fundamentally changed at the time of verification, no revision of the profile will be necessary, and the unit commander will be appropriately informed by DA Form 3349.

c. Physical profiles will be verified as follows:

(1) *Hospitals and other medical treatment facilities.* Prior to a patient's return to duty upon completion of hospitalization, regardless of duration (the profile of patients hospitalized over 6 months will be verified by a medical board) and at the time service members under-

go periodic, active duty, or active duty for training medical examinations or whenever a significant change in functional ability is believed to have occurred.

(2) *Unit and organizations.*

(a) Any time during training of new enlistees or inductees that such action appears warranted.

(b) Upon request of the unit commander.

(c) At the time of the periodic medical examination.

d. Except as noted in *f* below, an individual on active duty having a modifier "R" or "T" will have his profile reviewed at least every 3 months in order to insure that it reflects his current functional capability. Unit commanders are responsible for the initiation of his review (except when the individual is hospitalized).

e. Individuals being returned to a duty status pursuant to the approved findings of a physical evaluation board, the Army Physical Review Council or the Army Physical Disability Appeal Board under AR 635-40, will be given a physical profile commensurate with their functional capacity under the appropriate factor by The Surgeon General, Department of the Army. Assignment limitations will be established concurrently. All such cases will be referred to The Surgeon General, ATTN: MEDPS-SD by The Adjutant General 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 revised by a medical board if the individual's functional capacity warrants such action.

f. Tuberculous patients returned to a duty status who require antituberculous chemotherapy following hospitalization will be given a P-3-T profile for a period of 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.

g. The physical profile in controversial or equivocal cases may be verified or revised by a medical board, hospital commander, or major command surgeon, who may refer unusual cases, when appropriate, to The Surgeon General for final determination of an appropriate profile.

h. Revision of the physical profile for reservists not on active duty will be accomplished by the surgeon of the major command without medical board procedure. For members of the Army National Guard not on active duty, such profile revision will be accomplished by the unit medical officer or the state surgeon. See NGR 27.

9-9. Separation of Individuals With a Modifier "R" or "T" or a Code "V" or "W"

a. Individuals whose period of service expires and whose physical profile contains the modifier.

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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:

<i>Remove pages—</i>	<i>Insert pages—</i>
✓ 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.

By Order of the Secretary of the Army:

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

Official:

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l. Recent fracture of ribs, sternum, clavicle, or scapula.

m. Significant abnormal findings on physical examination of the chest.

2-25. Tuberculous Lesions

(See para 2-38.)

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

a. Active tuberculosis in any form or location.

b. Pulmonary tuberculosis, active within previous 2 years.

c. Substantiated history of one or more reactivations or relapses of pulmonary tuberculosis, or other definite evidence of poor host resistance to the tubercle bacillus.

2-26. Nontuberculous Lesions

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

a. Acute mastitis, chronic cystic mastitis, if more than mild.

b. Bronchial asthma, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday.

c. Bronchitis, chronic with evidence of pulmonary function disturbance.

d. Bronchiectasis.

e. Bronchopleural fistula.

f. Bullous or generalized pulmonary emphysema.

g. Chronic abscess of lung.

h. Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function or obscure the lung field in the roentgenogram.

i. Chronic mycotic diseases of the lung including coccidioidomycosis; residual cavitation or more than a few small sized inactive and stable residual modules demonstrated to be due to mycotic disease.

j. Empyema, residual sacculation or unhealed sinuses of chest wall following operation for empyema.

k. Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion.

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

m. Multiple cystic disease of the lung or solitary cyst which is large and incapacitating.

n. New growth of breast; history of mastectomy.

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

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

q. Sarcoidosis. See paragraph 2-38.

r. Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.

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

2-27. Mouth

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

a. Hard palate, perforation of.

b. Lip, unless satisfactorily repaired by surgery.

c. Leukoplakia, if severe.

d. Lips, unsightly mutilations of, from wounds, burns, or disease.

e. Ranula, if extensive. For other tumors see paragraphs 2-10 and 2-41.

2-28. Nose

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

a. Allergic manifestations.

(1) Chronic atrophic rhinitis.

(2) Hay fever if severe; and if not controllable by antihistamines or by desensitization, or both.

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

c. Nasal septum, perforation of:

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

(2) If progressive.

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

d. Sinusitis, acute.

e. 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 tissues, or symptoms requiring frequent medical attention.

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

2-29. Pharynx, Trachea, Esophagus, and Larynx

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

a. Esophagus, organic disease of, such as ulceration, varices, achalasia; peptic esophagitis; if confirmed by appropriate X-ray or esophagoscopy examinations.

b. Laryngeal paralysis, sensory or motor, due to any cause.

c. Larynx, organic disease of, such as neoplasm,

polyps, granuloma, ulceration; and chronic laryngitis.

d. Plica dysphonia venricularis.

e. Tracheostomy or tracheal fistula.

2-30. Other Defects and Diseases

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

a. Aphonia.

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

c. Destructive syphilitic disease of the mouth, nose, throat, larynx, or esophagus. (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

2-31. Neurological Disorders

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

a. Degenerative disorders.

(1) Cerebellar and Friedreich's ataxia.

(2) Cerebral arteriosclerosis.

(3) Encephalomyelitis, residuals of, which preclude the satisfactory performance of military duty.

(4) Huntington's chorea.

(5) Multiple sclerosis.

(6) Muscular atrophies and dystrophies of any type.

b. Miscellaneous.

(1) Congenital malformations if associated with neurological manifestations and meningocele even if uncomplicated:

(2) Migraine when frequent and incapacitating.

(3) Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause which is of such a nature or degree as to preclude the satisfactory performance of military duty.

i. Old ununited or malunited fractures, involving weight-bearing bones when there is sufficient shortening or deformity to prevent the performance of military duty.

8-12. Eyes and Vision

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. The causes listed in paragraphs 3-15 and 3-16, except as modified below.

b. Absence of an eye or when visual acuity has been reduced to light perception only when there is active eye disease in the other eye or the vision in the other eye does not correct to at least 20/30.

8-13. Genitourinary System

The causes of medical unfitness for physicians, dentists, and allied medical specialists are —

a. The causes listed in paragraphs 3-17 and 3-18.

b. Chronic prostatitis or hypertrophy of prostate, with evidence of urinary retention.

c. Kidney.

(1) Absence of one kidney where there is progressive disease or impairment of function in the remaining kidney.

(2) Cystic (polycystic kidney). Asymptomatic, history of.

d. Nephritis. A history of nephritis, with residuals such as hypertension or abnormal urinary or blood findings.

e. Nephrolithiasis. (Rescinded.)

8-14. Head and Neck

The causes of medical unfitness for physicians, dentists, and allied medical specialists are —

a. Paragraphs 3-19 and 3-20.

b. Skull defects are acceptable unless residual signs and symptoms are incapacitating in civilian practice.

8-15. Heart and Vascular System

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraphs 3-21, 3-22, and 3-23.

b. Auricular fibrillation. Paroxysmal auricular fibrillation with evidence of organic heart

disease, or persistent auricular fibrillation from any cause.

c. Auriculoventricular block, when due to organic heart disease.

d. Coarctation of the aorta and other significant congenital anomalies of the vascular system unless satisfactorily treated by surgical correction.

e. Hypertension. Blood pressure frequently elevated to 200/120 or more (which returns to normal limits with rest and sedatives) or a persistent diastolic pressure over 110-mm mercury even though cerebral, renal, cardiac, and retinal findings are normal.

f. Phlebitis. Recurrent phlebitis, other than mild. Residuals of phlebitis, such as persistent edema, dermatitis, ulceration, or claudication, which interfere materially with civilian practice, also make the individual medically unfit.

g. Valvular heart disease. Cardiac insufficiency at a functional capacity level of Class IIC or worse, American Heart Association (app VII).

h. Varicose veins associated with ulceration of the skin, symptomatic edema, or recurring incapacitating dermatitis.

i. Rheumatic fever.

(1) Residuals involving the heart at a functional capacity level of Class IIC or worse, American Heart Association (app VII).

(2) Verified history of recurrent attacks, cardiac involvement, or subacute bacterial endocarditis within the past 2 years.

8-16. Height, Weight, and Body Build (Rescinded.)

8-17. Lungs and Chest Wall

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraphs 3-24 and 3-25.

b. Bronchial asthma. Associated with emphysema of sufficient degree to interfere with performance of duty, or with frequent attacks controlled only by continuous systemic corticosteroid therapy, or with frequent attacks which are not controlled by oral medication.

c. Bronchiectasis and emphysema. When outpatient treatment or hospitalization is of

such frequency as to interfere materially with civilian practice. Bronchiectasis confined to one lobe is usually acceptable; however, the sacular, systic, and dry types, involving more than one lobe, make the individual medically unfit.

d. *Chronic bronchitis* complicated by disabling emphysema or requiring outpatient treatment or hospitalization of such frequency as to interfere materially with civilian practice.

e. *Pleurisy with effusion*. An individual with serofibrinous pleurisy due to known or proven acute or inflammatory conditions may be considered as acceptable for military service if there has been no recurrence for 1 year. If the effusion exceeds 100 cc, is not transient in character, and does not appear to be secondary to pneumonia or other demonstrable non-tuberculous disease, it will be considered to be a manifestation of active tuberculosis and will be disqualifying until the disease has become inactive and remained so for 5 years.

f. *Sarcoidosis*. Symptomatic pulmonary sarcoidosis which has not responded promptly to therapy or which is complicated by residual pulmonary fibrosis.

g. *Spontaneous pneumothorax* with recovery is acceptable.

h. *Tuberculosis*. Uncomplicated minimal tuberculosis which has been adequately treated is acceptable provided serial X-rays indicate that the lesion has remained stable for 2 years of full physical activity. An arbitrary time limit cannot definitely be established when an individual who has had tuberculosis can safely be accepted for military service. The 2 years specified may not always be applicable. The borderline between minimal and moderately advanced tuberculosis is not always definite since a lesion may be classified as either minimal or moderately advanced by several different competent observers. The difference between moderately advanced and far advanced tuberculosis disease is less controversial. If an individual has a history of minimal tuberculosis and X-rays reveal a lesion which is well calcified and which has appeared stable for 2 years of full physical activity, he can with reasonable certainty be expected to perform useful military service. If an individual

is on restricted activity or under treatment or has a moderately-advanced or far-advanced lesion, then he will be considered disqualified for military service for at least 2 years. Moderately-advanced lesions which have healed satisfactorily and have remained arrested for as long as 5 years with the individual allowed full activity are acceptable. An individual with a verified history of tuberculosis pleurisy with effusion which has not been clinically active or caused restricted activity within the previous 5 years is acceptable.

8-18. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraph 3-27.

b. *Polyps or mucocoeles*, when moderate to severe, suppurative, and unresponsive to treatment.

c. *Chronic sinusitis*, when moderate to severe, suppurative, and unresponsive to treatment.

8-19. Neurological Disorders

The causes of medical unfitness for physicians, dentists, and allied medical specialists are the causes listed in paragraph 3-28.

8-20. Psychoses, Psychoneuroses, and Personality Disorders

The causes of medical unfitness for physicians, dentists, and allied medical specialists are—

a. Paragraphs 3-29, 3-30, 3-31, and 3-32.

b. *Psychoneurosis* when severe and incapacitating for practice in civilian life. An individual who is undergoing continuous active neuropsychiatric therapy should be deferred and reconsidered at a later date. Neuropsychiatric consultation, in addition to Standard Forms 88 and 89 on an individual who is or claims to be a sexual deviate will be referred to The Surgeon General, ATTN: MEDPS-SP, Department of the Army, for an opinion of acceptability prior to qualification.

c. *Psychosis* of organic or functional etiology except if in complete remission for 2 years or more. Neuropsychiatric consultation, in addition to Standard Forms 88 and 89, will be sent to The Surgeon General, ATTN: MEDPS-SP,

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c. *Electrocardiographic evidence of major arrhythmias such as—*

(1) Atrial tachycardia, flutter, or fibrillation, ventricular tachycardia or fibrillation.

(2) Conduction defects such as first degree atrio-ventricular block and right bundle branch block. (These conditions occurring as isolated findings are not unfitting when cardiac evaluation reveals no cardiac disease.)

(3) Left bundle branch block, 2d and 3d degree AV block.

(4) Unequivocal electrocardiographic evidence of old or recent myocardial infarction; coronary insufficiency at rest or after stress; or evidence of heart muscle disease.

d. *Hypertrophy or dilatation of the heart as evidenced by clinical examination or roentgenographic examination and supported by electrocardiographic examination.* Care should be taken to distinguish abnormal enlargement from increased diastolic filling as seen in the well conditioned subject with a sinus bradycardia. Cases of enlarged heart by X-ray not supported by electrocardiographic examination will be forwarded to The Surgeon General for evaluation.

e. *Myocardial insufficiency (congestive circulatory failure, cardiac decompensation) obvious or covert, regardless of cause.*

f. *Paroxysmal tachycardia within the preceding 5 years, or at any time if recurrent or disabling or if associated with electrocardiographic evidence of accelerated A-V conduction (Wolff-Parkinson-White).*

★g. *Pericarditis; endocarditis; or myocarditis, history or finding of, except for a history of a single acute idiopathic or coxsackie pericarditis with no residuals, or tuberculous peri- and inactive for 2 years.*

h. *Tachycardia persistent with a resting pulse rate of 100 or more, regardless of cause.*

2-19. Vascular System

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

a. *Congenital or acquired lesions of the*

aorta and major vessels, such as syphilitic aortitis, demonstrable atherosclerosis which interferes with circulation, congenital or acquired dilation of the aorta (especially if associated with other features of Marfan's syndrome), and pronounced dilatation of the main pulmonary artery.

b. *Hypertension evidenced by preponderant blood pressure readings of 150-mm or more systolic in an individual over 35 years of age or preponderant readings of 140-mm or more systolic in an individual 35 years of age or less. Preponderant diastolic pressure over 90-mm diastolic is cause for rejection at any age.*

c. *Marked circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, severe peripheral vasomotor disturbances and sympatheticotonia.*

d. *Peripheral vascular disease including Raynaud's phenomena, Buerger's disease (thromboangiitis obliterans), erythromelalgia, arteriosclerotic and diabetic vascular diseases. Special tests will be employed in doubtful cases.*

e. *Thrombophlebitis.*

(1) History of thrombophlebitis with persistent thrombus or evidence of circulatory obstruction or deep venous incompetence in the involved veins.

(2) Recurrent thrombophlebitis.

f. *Varicose veins, if more than mild, or if associated with edema, skin ulceration, or residual scars from ulceration.*

2-20. Miscellaneous

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

c. *Aneurysm of the heart or major vessel, congenital or acquired.*

b. *History and evidence of a congenital abnormality which has been treated by surgery but with residual abnormalities or complications, for example: Patent ductus arteriosus with residual cardiac enlargement or pulmonary hypertension; resection of a coarctation of the aorta without a graft when there are other cardiac abnormalities or complications; closure*

of a secundum type atrial septal defect when there are residual abnormalities or complications.

c. Major congenital abnormalities and defects by the heart and vessels unless satisfactorily corrected without residuals or complica-

tions. Uncomplicated dextrocardia and other minor asymptomatic anomalies are acceptable.

d. Substantiated history of rheumatic fever or chorea within the previous 2 years, recurrent attacks of rheumatic fever or chorea at any time, or with evidence of residual cardiac damage.

Section XII. HEIGHT, WEIGHT, AND BODY BUILD

2-21. Height

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

a. For appointment.

(1) *Men.* Regular Army—Height below 66 inches or over 80 inches. (See administrative criteria in para 7-13.) Other—Height below 60 inches or over 80 inches.

(2) *Women.* Height below 58 inches or over 72 inches.

b. For enlistments and induction.

(1) *Men.* Height below 60 inches or over 80 inches for Army and Air Force.

(2) *Men.* Height below 60 inches and over 78 inches for Navy and Marine Corps.

(3) *Women.* Height below 58 inches or over 72 inches.

2-22. Weight

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

a. Weight related to height which is below the minimum shown in table I, appendix III for men and table II, appendix III for women.

b. Weight related to age and height which is in excess of the maximum shown in table I, appendix III for men and table II, appendix III

for women. See chapter 7 for special requirements pertaining to maximum weight standards applicable to women enlisting for and commissioned from Army Student Nurse and Army Student Dietician Programs.

2-23. Body Build

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

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

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

c. Evidences of congenital asthenia (slender bones; weak thorax; visceroptosis; severe, chronic constipation; or "drop heart" if marked in degree).

d. Obesity. Even though the individual's weight is within the maximum shown in table I or II, as appropriate, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's weight in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion of prescribed training.

Section XIII. LUNGS AND CHEST WALL

2-24. General

The following conditions are causes for rejection for appointment, enlistment and induction until further study indicates recovery without disqualifying sequelae:

a. Abnormal elevation of the diaphragm on either side.

b. Acute abscess of the lung.

c. Acute bronchitis until the condition is cured.

d. Acute fibrinous pleurisy, associated with acute nontuberculous pulmonary infection.

e. Acute mycotic disease of the lung such as coccidioidomycosis and histoplasmosis.

- f. *Acute nontuberculous pneumonia.*
- g. *Foreign body in trachea or bronchus.*
- h. *Foreign body of the chest wall causing symptoms.*
- i. *Lobectomy, history of, for a nontuberculous nonmalignant lesion with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.*
- j. *Other traumatic lesions of the chest or its contents.*
- ★k. *Pneumothorax of history thereof within 1 year of date of examination if due to simple trauma or surgery; within 3 years of date of examination if of spontaneous origin. Surgical correction is acceptable if no significant residual disease or deformity remains and pulmonary function tests are within normal limits.*
- l. *Recent fracture of ribs, sternum, clavicle, or scapula.*
- m. *Significant abnormal findings on physical examination of the chest.*

2-25. Tuberculous Lesions

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

- a. *Active tuberculosis in any form or location.*
- ★b. *Pulmonary tuberculosis, active within previous 2 years.*
- ★c. *Substantiated history of one or more reactivations or relapses of pulmonary tuberculosis, or other definite evidence of poor host resistance to the tubercle bacillus.*

2-26. Nontuberculous Lesions

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

- a. *Acute mastitis, chronic cystic mastitis, if more than mild.*

b. *Bronchial asthma, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday.*

- c. *Bronchitis, chronic with evidence of pulmonary function disturbance.*
- d. *Bronchiectasis.*
- e. *Bronchopleural fistula.*
- f. *Bullous or generalized pulmonary emphysema.*
- g. *Chronic abscess of lung.*

h. *Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function or obscure the lung field in the roentgenogram.*

i. *Chronic mycotic diseases of the lung including coccidioidomycosis; residual cavitation or more than a few small sized inactive and stable residual modules demonstrated to be due to mycotic disease.*

j. *Empyema, residual sacculation or unhealed sinuses of chest wall following operation for empyema.*

k. *Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion.*

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

m. *Multiple cystic disease of the lung or solitary cyst which is large and incapacitating.*

n. *New growth of breast; history of mastectomy.*

o. *Osteomyelitis of rib, sternum, clavicle, scapula, or vertebra.*

★p. *Pleurisy with effusion of unknown origin within the previous 2 years.*

q. *Sarcoidosis. See paragraph 2-38.*

r. *Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.*

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

2-27. 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*, if severe.

d. *Lips*, unsightly mutilations of, from wounds, burns, or disease.

e. *Ranula*, if extensive. For other tumors see paragraphs 2-10 and 2-41.

2-28. Nose

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

★a. *Allergic manifestations*.

(1) Chronic atrophic rhinitis.

(2) Hay fever if severe; and if not controllable by antihistamines or by desensitization, or both.

b. *Choana, atresia, or stenosis* of, if symptomatic.

c. *Nasal septum*, perforation of:

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

(2) If progressive.

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

d. *Sinusitis*, acute.

e. *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 tissues, or symptoms requiring frequent medical attention.

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

2-29. Pharynx, Trachea, Esophagus, and Larynx

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

a. *Esophagus*, organic disease of, such as ulceration, varices, achalasia; peptic esophagitis; if confirmed by appropriate X-ray or esophagogoscopic examinations.

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

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

d. *Plica dysphonia venricularis*.

e. *Tracheostomy or tracheal fistula*.

2-30. Other Defects and Diseases

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

a. *Aphonia*.

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

c. *Destructive syphilitic disease of the mouth, nose, throat, larynx, or esophagus*. (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

2-31. Neurological Disorders

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

a. *Degenerative disorders*.

(1) Cerebellar and Friedreich's ataxia.

(2) Cerebral arteriosclerosis.

(3) *Encephalomyelitis*, residuals of, which preclude the satisfactory performance of military duty.

(4) Huntington's chorea.

(5) Multiple sclerosis.

(6) Muscular atrophies and dystrophies of any type.

b. *Miscellaneous*.

(1) Congenital malformations if associated with neurological manifestations and meningocele even if uncomplicated.

(2) Migraine when frequent and incapacitating.

(3) Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause which is of such a nature or degree as to preclude the satisfactory performance of military duty.

plaint without symptoms and objective signs is required.

c. Deviation or curvature of spine from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis, spina bifida occulta, spondylolysis, etc.), if—

(1) Mobility and weight-bearing power is poor.

(2) More than moderate restriction of normal physical activities is required.

(3) Of such a nature as to prevent the individual from following a *physically active vocation* in civilian life.

(4) Of a degree which will interfere with the wearing of a uniform or military equipment.

(5) Symptomatic, associated with positive physical finding(s) demonstrable by X-ray.

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

e. Granulomatous diseases either active or healed.

f. Healed fracture of the spine or pelvic bones with associated symptoms which have

prevented the individual from following a *physically active vocation* in civilian life or which preclude the satisfactory performance of military duty.

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

h. Spondylolysis or spondylolisthesis that is symptomatic or is likely to interfere with performance of duty or is likely to require assignment limitations.

2-37. 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 of rib, sternum, clavicle, scapula, or vertebra.

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

Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

2-38. Systemic Disease

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

a. Dermatomyositis.

b. Lupus erythematosus: acute, subacute, or chronic.

c. Progressive systemic sclerosis.

d. Reiter's Disease.

e. Sarcoidosis.

f. Scleroderma, diffuse type.

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) (Deleted).

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 paragraph 2-28.

- (2) Asthma. See paragraph 2-26b.
- (3) Allergic dermatoses. See paragraph 2-35.
- (4) Visceral, abdominal, and cerebral allergy, if severe or not responsive to treatment.
- ★(5) Bona fide history of moderate or severe generalized (as opposed to local) allergic reaction to insect bites or stings. Bona fide history of severe generalized reaction to common foods, e.g., milk, eggs, beef, and pork.
- 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 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 examinee medically unacceptable.*
- e. *Cold injury, residuals of, (example: frostbite, chilblain, immersion foot, or trench foot) such as 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, trichlorethylene, 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 preclude the satisfactory performance of military duty.*

Section XX. TUMORS AND MALIGNANT DISEASES

2-40. Benign Tumors

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

- a. *Any tumor of the—*
- (1) Auditory canal, if obstructive.
 - (2) Eye or orbit (see also para 2-2a(6)).
 - (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 of original lesion.
- b. *Benign tumors of the abdominal wall if*

sufficiently large to interfere with military duty.

c. *Benign tumors of bone likely to continue to enlarge, be subjected to trauma during military service, or show malignant potential.*

d. *Brain 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.*

e. *Tongue, benign tumor of, if it interferes with function.*

f. *Breast, thoracic contents, or chest wall, tumors, of, other than fibromata lipomata, and*

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inclusion or sebaceous cysts which do not interfere with military duty.

g. For tumors of the internal or external female genitalia see paragraph 2-14h.

2-41. Malignant Diseases and Tumors

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

a. Leukemia, acute or chronic.

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 635-89, AR 635-105, AR 635-206, and AR 635-212.

e. Enlisted 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 enlistment or induction), may be processed for separation as provided in AR 635-200 or AR 135-178 if otherwise qualified.

[THE FOLLOWING SECTIONS II THROUGH XX SET FORTH BY BROAD GENERAL CATEGORY, THOSE MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH NORMALLY RENDER A MEMBER UNFIT FOR FURTHER MILITARY SERVICE.]

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 to 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. *Prostatitis, 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.

n. *Rectum, stricture of*. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, 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 gastro-jejunostomy 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.

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 mastoidectomy. 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.

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CHAPTER 2

MEDICAL FITNESS STANDARDS FOR APPOINTMENT, ENLISTMENT, AND INDUCTION
(Short Title: PROCUREMENT MEDICAL FITNESS STANDARDS)

Section I. GENERAL

2-1. Scope

This chapter sets forth the medical conditions and physical defects which are causes for rejection for military service in peacetime. For medical fitness standards during mobilization, see chapter 6.

★2-2. Applicability

These standards apply to—

a. Male and female applicants for appointment as commissioned or warrant officers in the U.S. Army, regardless of component. (Special categories of personnel such as physicians, dentists, and other specialists liable for military service under the Military Selective Service Act of 1967 will be procured under standards prescribed by the Secretary of the Army in appropriate personnel procurement program directives.)

b. Male and female applicants for enlistment in the U.S. Army, regardless of component. These standards are applicable until enlistees have completed 4 months of active duty or active duty for training under the Reserve Enlistment Program 1963 for medical conditions or physical defects existing prior to original enlistment or induction. (See also AR 635-40, AR 635-200, AR 135-178, and NGR

25-3 for administrative procedure for separation for medically unfitting conditions that existed prior to service.)

c. Male and female applicants for reenlistment in the U.S. Army (regardless of component) after a period of more than 90 days has elapsed since discharge.

d. Applicants for the Army ROTC Scholarship Program, the Advanced Course Army ROTC and other personnel procurement programs, other than induction for which these standards are prescribed.

e. Retention of cadets in the United States Military Academy.

f. Registrants who undergo preinduction or induction medical examination pursuant to the Military Selective Service Act of 1967 except medical and dental and allied medical specialists registrants who are to be evaluated under chapter 8.

g. "Draft-eligible" male applicants for enlistment in the U.S. Air Force.

h. Male applicants for enlistment or reenlistment in the U.S. Navy or Naval Reserve.

i. "Chargeable accessions" for enlistment in the U.S. Marine Corps or Marine Corps Reserve.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

2-3. Abdominal Organs and Gastrointestinal System

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

a. *Cholecystectomy*, sequelae of, such as postoperative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, or incisional hernia, or post-

cholecystectomy syndrome when symptoms are so severe as to interfere with normal performance of duty.

b. *Cholecystitis*, acute or chronic, with or without cholelithiasis, if diagnosis is confirmed by usual laboratory procedures or authentic medical records.

c. *Cirrhosis* regardless of the absence of manifestations such as jaundice, ascites or known esophageal varices, abnormal liver function tests with or without history of chronic alcoholism.

d. *Fistula* in ano.

e. *Gastritis*, chronic hypertrophic, severe.

f. *Hemorrhoids*.

(1) External hemorrhoids producing marked symptoms.

(2) Internal hemorrhoids, if large or accompanied with hemorrhage or protruding intermittently or constantly.

g. *Hepatitis* within the preceding 6 months, or persistence of symptoms after a reasonable period of time with objective evidence of impairment of liver function.

h. *Hernia*:

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

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

i. *Intestinal obstruction* or authenticated history of more than one episode, if either occurred during the preceding 5 years, or if resulting condition remains which produces significant symptoms or requires treatment.

j. *Megacolon* of more than minimal degree, *diverticulitis*, *regional enteritis*, and *ulcerative colitis*. *Irritable colon* of more than moderate degree.

k. *Pancreas*, acute or chronic disease of, if proven by laboratory tests, or authenticated medical records.

l. *Rectum*, stricture or prolapse of.

m. *Resection, gastric or of bowel; or gastro-*

enterostomy; however minimal intestinal resection in infancy or childhood (for example: for intussusception or pyloric stenosis) is acceptable if the individual has been asymptomatic since the resection and if surgical consultation (to include upper and lower gastrointestinal series) gives complete clearance.

n. *Scars*.

(1) Scars, abdominal, regardless of cause, which show hernial bulging or which interfere with movements.

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

o. *Sinuses* of the abdominal wall.

p. *Splenectomy*, except when accomplished for the following:

(1) Trauma.

(2) Causes unrelated to diseases of the spleen.

(3) Hereditary spherocytosis.

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

q. *Tumors*. See paragraphs 2-40 and 2-41.

r. *Ulcer*:

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

(2) Authentic history of surgical operation(s) for gastric or duodenal ulcer.

s. *Other congenital or acquired abnormalities* and defects which preclude satisfactory performance of military duty or which 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 condition and basic cause are corrected.

(2) Deficiency anemia, not controlled by medication.

(3) Abnormal destruction of RBC's: Hemolytic anemia.

(4) Faulty RBC construction: Hereditary hemolytic anemia, thalassemia and sickle cell anemia.

(5) Myelophthisic anemia: Myelomatosis, leukemia, Hodgkin's disease.

(6) Primary refractory anemia: Aplastic anemia, DiGuglielmo's syndrome.

b. *Hemorrhagic states*:

(1) Due to changes in coagulation system (hemophilia, etc.).

ous, asymptomatic, less than 3 centimeters in diameter, with no general enlargement of the uterus. See also paragraphs 2-40 and 2-41.

i. Oophoritis, acute or chronic.

j. Ovarian cysts, persistent and considered to be of clinical significance.

k. Pregnancy.

l. Salpingitis, acute or chronic.

m. Testicle(s). (See also para 2-40 and 2-41.)

(1) Absence or nondescent of both testicles.

(2) Undiagnosed enlargement or mass of testicle or epididymis.

★(3) Undescended testicle.

n. Urethritis, acute or chronic, other than gonorrhoeal urethritis without complications.

o. 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.

p. Vagina.

(1) Congenital abnormalities or severe lacerations of the vagina.

(2) Vaginitis, acute or chronic, manifested by leukorrhoea.

q. Varicocele or hydrocele, if large or painful.

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 complications (adhesions, disfiguring scars, etc.) residual to surgical correction of these conditions.

2-15. Urinary System

(See para 2-8, 2-40, and 2-41.)

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

a. Albuminuria if persistent or recurrent in-

cluding so-called orthostatic or functional albuminuria.

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

c. Enuresis determine to be a symptom of an organic defect not amenable to treatment. (See also para 2-34c.)

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

e. Hematuria, cylindruria, or other findings indicative of renal tract disease.

f. Incontinence of urine.

g. 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) Hydronephrosis or pyonephrosis.

(5) Nephritis, acute or chronic.

(6) Pyelitis, pyelonephritis.

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.

k. 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.

l. Skeneitis.

m. Urethra.

(1) Stricture of the urethra.

(2) Urethritis, acute or chronic, other than gonorrhoeal urethritis without complications.

n. Urinary fistula.

o. Other diseases and defects of the urinary system which obviously preclude satisfactory

performance of duty or which 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 which 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 paragraph 2-31.

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

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

d. Depressed fractures near central sulcus with or without convulsive seizures.

★*e. Loss or congenital absence* of the bony substance of the skull not successfully corrected by reconstructive material:

(1) All cases involving absence of the bony substance of the skull which have been corrected but in which the defect is in excess of 1 square inch or the size of a 25 cent piece, will be referred to The Surgeon General together with a report of consultation;

(2) The report of consultation will include an evaluation of any evidence of alteration of brain function in any of its several spheres, i.e., intelligence, judgment, perception, behavior, motor control and sensory function as well as any evidence of active bone disease

or other related complications. Current X-rays and other pertinent laboratory data will accompany such a report of consultation.

f. Unsightly deformities, such as large birthmarks, large hairy moles, extensive scars, and mutilations due to injuries or surgical operations; ulcerations; fistulae, atrophy, or paralysis of part of the face or head.

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-ray is not considered to meet this 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, of any type.

d. Healed tuberculosis lymph nodes when extensive in number of densely calcified.

e. 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 so disfiguring as to make the individual objectionable in common social relationships.

f. Spastic contraction of the muscles of the neck, persistent, and chronic.

g. Tumor of thyroid or other structures of the neck. See paragraphs 2-40 and 2-41.

Section XI. HEART AND VASCULAR SYSTEM

2-18. Heart

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

a. All organic valvular diseases of the heart, including those improved by surgical procedures.

b. Coronary artery disease or myocardial infarction, old or recent or true angina pectoris, at any time.

2-10

c. Electrocardiographic evidence of major arrhythmias such as—

(1) Atrial tachycardia, flutter, or fibrillation, ventricular tachycardia or fibrillation.

(2) Conduction defects such as first degree atrio-ventricular block and right bundle branch block. (These conditions occurring as isolated findings are not unfitting when cardiac evaluation reveals no cardiac disease.)

(3) Left bundle branch block, 2d and 3d degree AV block.

(4) Unequivocal electrocardiographic evidence of old or recent myocardial infarction; coronary insufficiency at rest or after stress; or evidence of heart muscle disease.

d. Hypertrophy or dilatation of the heart as evidenced by clinical examination or roentgenographic examination and supported by electrocardiographic examination. Care should be taken to distinguish abnormal enlargement from increased diastolic filling as seen in the well conditioned subject with a sinus bradycardia. Cases of enlarged heart by X-ray not supported by electrocardiographic examination will be forwarded to The Surgeon General for evaluation.

e. Myocardial insufficiency (congestive circulatory failure, cardiac decompensation) obvious or covert, regardless of cause.

f. Paroxysmal tachycardia within the preceding 5 years, or at any time if recurrent or disabling or if associated with electrocardiographic evidence of accelerated A-V conduction (Wolff-Parkinson-White).

g. Pericarditis; endocarditis; or myocarditis, history or finding of, except for a history of a single acute idiopathic or coxsackie pericarditis with no residuals.

h. Tachycardia persistent with a resting pulse rate of 100 or more, regardless of cause.

2-19. Vascular System

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

a. Congenital or acquired lesions of the aorta and major vessels, such as syphilitic aortitis, demonstrable atherosclerosis which interferes with circulation, congenital or acquired dilatation of the aorta (especially if associated with other features of Marfan's syndrome), and pronounced dilatation of the main pulmonary artery.

b. Hypertension evidenced by preponderant blood pressure readings of 150-mm or more systolic in an individual over 35 years of age or preponderant readings of 140-mm or more systolic in an individual 35 years of age or less. Preponderant diastolic pressure over

90-mm diastolic is cause for rejection at any age.

c. Marked circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, severe peripheral vasomotor disturbances and sympatheticotonia.

d. Peripheral vascular disease including Raynaud's phenomena, Buerger's disease (thromboangiitis obliterans), erythromelalgia, arteriosclerotic and diabetic vascular diseases. Special tests will be employed in doubtful cases.

e. Thrombophlebitis.

(1) History of thrombophlebitis with persistent thrombus or evidence of circulatory obstruction or deep venous incompetence in the involved veins.

(2) Recurrent thrombophlebitis.

f. Varicose veins, if more than mild, or if associated with edema, skin ulceration, or residual scars from ulceration.

2-20. Miscellaneous

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

a. Aneurysm of the heart or major vessel, congenital or acquired.

b. History and evidence of a congenital abnormality which has been treated by surgery but with residual abnormalities or complications, for example: Patent ductus arteriosus with residual cardiac enlargement or pulmonary hypertension; resection of a coarctation of the aorta without a graft when there are other cardiac abnormalities or complications; closure of a secundum type atrial septal defect when there are residual abnormalities or complications.

c. Major congenital abnormalities and defects of the heart and vessels unless satisfactorily corrected without residuals or complications. Uncomplicated dextrocardia and other minor asymptomatic anomalies are acceptable.

d. Substantiated history of rheumatic fever or chorea within the previous 2 years, recurrent attacks of rheumatic fever or chorea at any time, or with evidence of residual cardiac damage.

Section XII. HEIGHT, WEIGHT, AND BODY BUILD

★2-21. Height

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

a. For appointment.

(1) *Men.* Regular Army—Height below 66 inches or over 80 inches. (See administrative criteria in para 7-13.) Other—Height below 60 inches or over 80 inches.

(2) *Women.* Height below 58 inches or over 72 inches.

b. For enlistments and induction.

(1) *Men.* Height below 60 inches or over 80 inches for Army and Air Force.

(2) *Men.* Height below 60 inches and over 78 inches for Navy and Marine Corps.

(3) *Women.* Height below 58 inches or over 72 inches.

2-22. Weight

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

a. Weight related to height which is below the minimum shown in table I, appendix III for men and table II, appendix III for women.

b. Weight related to age and height which is in excess of the maximum shown in table I, appendix III for men and table II, appendix

III for women. See chapter 7 for special requirements pertaining to maximum weight standards applicable to women enlisting for and commissioned from Army Student Nurse and Army Student Dietician Programs.

2-23. Body Build

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

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

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

c. Evidences of congenital asthenia (slender bones; weak thorax; visceroptosis; severe, chronic constipation; or "drop heart" if marked in degree).

d. Obesity. Even though the individual's weight is within the maximum shown in table I or II, as appropriate, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's weight in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion of prescribed training.

Section XIII. LUNGS AND CHEST WALL

2-24. General

The following conditions are causes for rejection for appointment, enlistment and induction til further study indicates recovery without disqualifying sequelae:

a. Abnormal elevation of the diaphragm on either side.

b. Acute abscess of the lung.

c. Acute bronchitis until the condition is cured.

d. Acute fibrinous pleurisy, associated with acute nontuberculous pulmonary infection.

e. Acute mycotic disease of the lung such as coccidioidomycosis and histoplasmosis.

f. Acute nontuberculous pneumonia.

g. Foreign body in trachea or bronchus.

h. Foreign body of the chest wall causing symptoms.

i. Lobectomy, history of, for a nontuberculous nonmalignant lesion with residual pulmonary disease. Removal of more than one lobe is cause for rejection regardless of the absence of residuals.

j. Other traumatic lesions of the chest or its contents.

k. Pneumothorax, regardless of etiology or history thereof.

l. Recent fracture of ribs, sternum, clavicle, or scapula.

m. Significant abnormal findings on physical examination of the chest.

2-25. Tuberculous Lesions

(See also para 2-38.)

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

a. Active tuberculosis in any form or location.

b. Pulmonary tuberculosis, active within the past 5 years.

c. Substantiated history or X-ray findings of pulmonary tuberculosis of more than minimal extent at any time; or minimal tuberculosis not treated with a full year of approved chemotherapy or combined chemotherapy and surgery; or a history of pulmonary tuberculosis with reactivation, relapse, or other evidence of poor host resistance.

2-26. Nontuberculous Lesions

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

a. Acute mastitis, chronic cystic mastitis, if more than mild.

b. Bronchial asthma, except for childhood asthma with a trustworthy history of freedom from symptoms since the 12th birthday.

c. Bronchitis, chronic with evidence of pulmonary function disturbance.

d. Bronchiectasis.

e. Bronchopleural fistula.

f. Bullous or generalized pulmonary emphysema.

g. Chronic abscess of lung.

h. Chronic fibrous pleuritis of sufficient extent to interfere with pulmonary function or obscure the lung field in the roentgenogram.

i. Chronic mycotic diseases of the lung including coccidioidomycosis; residual cavitation or more than a few small sized inactive and stable residual modules demonstrated to be due to mycotic disease.

j. Empyema, residual sacculation or unhealed sinuses of chest wall following operation for empyema.

k. Extensive pulmonary fibrosis from any cause, producing dyspnea on exertion.

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

m. Multiple cystic disease of the lung or solitary cyst which is large and incapacitating.

n. New growth of breast; history of mastectomy.

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

p. Pleurisy with effusion of unknown origin within the preceding 5 years.

q. Sarcoidosis. See paragraph 2-38.

r. Suppurative periostitis of rib, sternum, clavicle, scapula, or vertebra.

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

2-27. 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, if severe.

d. Lips, unsightly mutilations of, from wounds, burns, or disease.

e. Ranula, if extensive. For other tumors see paragraphs 2-40 and 2-41.

2-28. Nose

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

a. Allergic manifestations.

- (1) Chronic atrophic rhinitis.
- (2) Hay fever if severe; or if not controllable by antihistamines or by desensitization, or both.

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

c. Nasal septum, perforation of:

- (1) Associated with interference of function, ulceration of crusting, and when the result of organic disease.
- (2) If progressive.
- (3) If respiration is accompanied by a whistling sound.

*d. Sinusitis, acute.**e. 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 tissues, or symptoms requiring frequent medical attention.
- (2) Confirmed by transillumination or X-ray examination or both.

2-29. Pharynx, Trachea, Esophagus, and Larynx

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

a. Esophagus, organic disease of, such as ulceration, varices, achalasia; peptic esophagitis; if confirmed by appropriate X-ray or esophagogoscopic examinations.

b. Laryngeal paralysis, sensory or motor, due to any cause.

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

*d. Plica dysphonia venricularis.**e. Tracheostomy or tracheal fistula.***2-30. Other Defects and Diseases**

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

a. Aphonia.

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

c. Destructive syphilitic disease of the mouth, nose, throat, larynx, or esophagus. (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.**2-31. Neurological Disorders**

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

a. Degenerative disorders.

- (1) Cerebellar and Friedreich's ataxia.
- (2) Cerebral arteriosclerosis.
- (3) Encephalomyelitis, residuals of, which preclude the satisfactory performance of military duty.
- (4) Huntington's chorea.
- (5) Multiple sclerosis.
- (6) Muscular atrophies and dystrophies of any type.

b. Miscellaneous.

- (1) Congenital malformations if associated with neurological manifestations and meningocele even if uncomplicated.
- (2) Migraine when frequent and incapacitating.
- (3) Paralysis or weakness, deformity, discoordination, pain, sensory disturbance, intellectual deficit, disturbances of consciousness, or personality abnormalities regardless of cause which is of such a nature or degree as to preclude the satisfactory performance of military duty.

plaint without symptoms and objective signs is required.

c. Deviation or curvature of spine from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis, spina bifida occulta, spondylolysis, etc.), if—

- (1) Mobility and weight-bearing power is poor.
- (2) More than moderate restriction of normal physical activities is required.
- (3) Of such a nature as to prevent the individual from following a *physically active vocation* in civilian life.
- (4) Of a degree which will interfere with the wearing of a uniform or military equipment.
- (5) Symptomatic, associated with positive physical finding(s) demonstrable by X-ray.

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

e. Granulomatous diseases either active or healed.

f. Healed fracture of the spine or pelvic bones

with associated symptoms which have prevented the individual from following a *physically active vocation* in civilian life or which preclude the satisfactory performance of military duty.

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

★*h. Spondylolysis or spondylolisthesis* that is symptomatic or is likely to interfere with performance of duty or is likely to require assignment limitations.

2-37. Scapulae, Clavicles, and Ribs

(See also 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 of rib, sternum, clavicle, scapula, or vertebra.

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

Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

2-38. Systemic Diseases

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

a. Dermatomyositis.

b. Lupus erythematosus; acute, subacute, or chronic.

c. Progressive systemic sclerosis.

d. Reiter's Disease.

e. Sarcoidosis.

f. Scleroderma, diffuse type.

g. Tuberculosis:

- (1) Active tuberculosis in any form or location.
- (2) Pulmonary tuberculosis. See paragraph 2-25.

(3) Confirmed history of tuberculosis of a bone or joint, genitourinary organs, intestines, peritoneum or mesenteric glands at any time.

(4) Meningeal tuberculosis; disseminated tuberculosis.

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 paragraph 2-28.
- (2) Asthma. See paragraph 2-26b.
- (3) Allergic dermatoses. See paragraph 2-35.

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

★(5) Bonafide history of moderate or severe generalized (as opposed to local) allergic reaction to insect bites or stings which has not subsequently been successfully treated by a minimum of one year of hyposensitization. Bonafide history of severe generalized reaction to common foods, e.g., milk, eggs, beef, and pork.

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 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 examinee medically unacceptable.

e. *Cold injury*, residuals of, (example: frostbite, chilblain, immersion foot, or trench foot) such as 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 sev-

eral 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, trichlorethylene, 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 preclude the satisfactory performance of military duty.

Section XX. TUMORS AND MALIGNANT DISEASES

2-40. Benign Tumors

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

a. *Any tumor of the—*

(1) Auditory canal, if obstructive.

(2) Eye or orbit (see also para 2-2a(6)).

(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 of original lesion.

b. *Benign tumors of the abdominal wall* if sufficiently large to interfere with military duty.

c. *Benign tumors of bone* likely to continue to enlarge, be subjected to trauma during military service, or show malignant potential.

d. *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.

e. *Tongue, benign tumor of*, if it interferes with function.

f. *Breast, thoracic contents, or chest wall*, tumors, of, other than fibromata lipomata, and inclusion or sebaceous cysts which do not interfere with military duty.

g. *For tumors of the internal or external female genitalia* see paragraph 2-14h.

2-41. Malignant Diseases and Tumors

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

a. *Leukemia*, acute or chronic.

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

Section I. GENERAL

3-1. Scope

This chapter sets forth the various medical conditions and physical defects which normally 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 U.S. Army regardless of component. (See AR 635-40, AR 135-175, NGR 20-6, and other appropriate regulations for administrative procedures for separation for medically unfitting conditions that existed prior to service.)

(2) All enlisted personnel of the U.S. Army regardless of component or duty status. (For those individuals who are found to be medically unfit for entry into service because of an EPTS medical condition or physical defect discovered within the first 4 months of active duty or active duty for training under the Reserve Enlistment Program of 1963, but not medically unfit under this chapter, see paragraph 2-2b of this regulation, and AR 635-200.)

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

(1) Retention of officers, warrant officers and enlisted personnel (regardless of component) 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 (regardless of component) who have been retired except those retired for temporary disability.

3-3. Policies

a. Normally, members with conditions listed in this chapter will be considered unfit by reason of physical disability; 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 must be decided upon the relevant facts and a determination of fitness or unfitness must be made dependent upon the abilities of the member to perform the duties of his office, grade, rank, or rating in such a manner as to reasonably fulfill the purpose of his employment in the military service.

b. The various medical conditions and physical defects which may render a member unfit for military duty by reason of physical disability are not necessarily 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 normally makes an individual unfit because of physical disability if—

(1) The individual is precluded from a reasonable fulfillment of the purpose of his employment in the military service, or

(2) The individual's health or well-being would be compromised if he were to remain in the military service, or

(3) The individual's retention in the military service would prejudice the best interests of the Government.

c. A member will not be declared unfit for

military service because of impairments which were known to exist at time of his acceptance for military service, and which have remained essentially the same in degree of severity since acceptance and have not interfered with his 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 (chapter 10, AR 635-40, AR 140-120, and NGR 27) will not necessarily be declared unfit because of physical disability solely because of the defect which caused his special status, when the impairment has remained essentially unchanged and has not interfered with his performance of duty. When his separation or retirement is authorized or required for some other reason, this impairment, like any other, will be evaluated in connection with his processing for separation or retirement.

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 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 prin-

ciples and medical judgment; contradiction of those factors must be supported by conclusive evidence.

h. Latent impairments will be accorded appropriate consideration both in determining unfitness because of physical disability and in assessing the degree of disability.

i. Every effort will be made to accurately record the physical condition of each member throughout his Army career. A member undergoing examination and evaluation incident to retirement, however, will be judged on actual existing impairments and disabilities with due consideration for latent impairments. It is important, therefore, that all medical conditions and physical defects which are present, be recorded, no matter how minor they may appear. Performance of duty despite an impairment will not be considered presumptive evidence of physical fitness.

★3-4. Disposition of Members Who May be Unfit Because of Physical Disability

a. Members who are believed to be unfit because of physical disability, or who have one of the conditions listed in this chapter, will be processed as prescribed in AR 40-3 and AR 635-40 to determine their eligibility for physical disability benefits under chapter 61, title 10, United States Code. In certain instances, continuance on active duty despite unfitness because of physical disability may be appropriate as indicated below. 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 be retained on active duty and their disability separation or retirement processing deferred for the duration of the mobilization or as directed by the Secretary of the Army. During mobilization, those who are 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 do not meet retention medical fitness standards (mobilization medical fitness standards when

duty training will be processed as prescribed in AR 40-3 and AR 635-40 (~~to be published~~)-*Cl 22*

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 635-89, AR 635-105, AR 635-206, and AR 635-212.

e. Enlisted 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 enlistment or induction), may be processed for separation as provided in AR 635-200 or AR 135-178 if otherwise qualified.

[THE FOLLOWING SECTIONS II THROUGH XX SET FORTH BY BROAD GENERAL CATEGORY, THOSE MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH NORMALLY RENDER A MEMBER UNFIT FOR FURTHER MILITARY SERVICE.]

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 to 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 insulin.

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.

n. *Rectum, stricture of*. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, 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 gastro-jeunostomy 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 epi-

gastric 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*.

Section IV. DENTAL

3-8. Dental Diseases and Abnormalities of the Jaws

Diseases of the jaws or associated tissues when, following restorative surgery, there remain resid-

uals 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, following mastoidectomy*. Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care or hospitalization.

d. *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.

e. *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 assignment 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 is being considered for separation or retirement for some other administrative reason, the medical

examination discloses a substantial hearing defect. This refers particularly to cases requiring hearing aids and those having hearing levels which may be rateable at 30 to 40 percent or more in accordance with the Veterans Administration Schedule for Rating Disabilities. It should be noted that the decibel levels used in the VASRD are without hearing aids, and are related to American Standards Association calibrated testing equipment. Tests performed on International Stand-

ards Organization calibrated equipment must be converted to the ASA standard before arriving at a decision regarding the referral of a member for physical disability evaluation under this paragraph. It should be further noted that past performance of duty does not, per se, preclude separation or retirement because of physical disability caused by a hearing defect.

c. Processing of such individuals will be in accordance with AR 40-3.

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 malign-

ant 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 appendix IV.

(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.* Pronation or supination to the first quarter of the normal arc.

c. Dislocated shoulder. When not repairable or surgery is contraindicated.

3-13. Lower Extremities

(See also 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 prevents 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 appendix IV.

(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 also 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 documented history of recurrent incapacity for prolonged periods. For arthritis due to gonococcal or tuberculous infection see paragraphs 3-35h(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. 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) *Arthoplasty.* 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.

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. 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. Chronic congestive (closed angle) glaucoma or chronic noncongestive (open angle) glaucoma. If well established with demonstrable changes in the optic disk or visual fields, or not amenable to treatment.

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 criterial 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. Anisikonia. Subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by isekonic 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) Visual acuity which cannot be corrected to at least 20/40 in the better eye, or

(2) Visual acuity in the poorer eye has been reduced to light perception or less, or

(3) An eye has been enucleated.

f. Visual field. Bilateral concentric construction to less than 20°.

Section IX. GENITOURINARY SYSTEM

3-17. Genitourinary System

a. Cystitis. When complications or residuals of 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 if 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 pres-

sure 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, eyeground 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

Section XII. LUNGS AND CHEST WALL

3-24. Tuberculous Lesions

(See TB Med 236.)

a. *Pulmonary tuberculosis.*

- (1) When the disease in 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 12 to 15 months including an appropriate period of convalescence.
- (2) When a member of the U.S. Army Reserve not on active duty who has the disease probably will require treatment for more than 12 to 15 months including an appropriate period of convalescence before he will be capable of performing fulltime 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 20-4 (officers) or NGR 25-3 (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. *Bronchial asthma.* Associated with emphysema of sufficient severity to interfere with the satisfactory performance of duty, or with frequent attacks controlled only by continuing corticosteroid therapy, or with frequent attacks not controlled by other oral 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 sympto-

matic, 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 fibrocalcific residuals of such a degree as to cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

o. *Pulmonary sarcoidosis.* If not responding to therapy and complicated by demonstrable moderate reduction 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. Of more than one lobe or if pulmonary function is seriously impaired.

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

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.

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.*

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 degree as to definitely interfere with the performance of duty.

Section XV. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

3-29. Psychoses

Recurrent psychotic episodes, existing symptoms or residuals thereof, or a recent history of psychotic reaction sufficient to interfere with performance of duty or with social adjustment.

3-30. Psychoneuroses

Persistence or severity of symptoms sufficient to require frequent hospitalization, or the lack of improvement of symptoms by hospitalization, or the necessity for duty in a very protected environment. (Incapacity because of neurosis must be distinguished from weakness of motivation or underlying personality disorder.)

3-31. Personality Disorders

a. Character and behavior disorders. Character and behavior disorders are considered to render an individual administratively unfit rather than unfit because of physical disability. Inter-

ference with performance of effective duty will be dealt with through appropriate administrative channels.

b. Transient personality disruptions. Transient personality disruptions of a nonpsychotic nature and situational maladjustments due to acute or special stress do not render an individual unfit because of physical disability.

c. Sexual deviate. Confirmation of abnormal sexual practices which are not a manifestation of psychiatric disease provides a basis for medical recommendation for administrative separation or other nondisability disposition.

3-32. Disorders of Intelligence

Individuals determined to have primary mental deficiency or special learning defect of such degree as to interfere with the satisfactory performance of duty are administratively unfit and should be recommended for administrative separation.

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 suppurative and folliculitis decalvans.

o. Hyperhidrosis. Of 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 3-35h(7).

ab. Ulcers of the skin. Not responsive to treat-

ment 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 modern 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, deformity, and arthritic changes.

c. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remediable 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 two inches deviation of tips of spinous process from the midline.

Section XVIII. SYSTEMIC DISEASES, AND MISCELLANEOUS CONDITIONS AND DEFECTS

3-35. Systemic Diseases

a. Blastomycosis.

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

c. Leprosy. Any type.

d. Lupus erythematosus disseminated, chronic.

e. Myasthenia gravis.

f. Porphyria cutanea tarda.

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

h. Tuberculosis.

(1) Meningitis, tuberculous.

(2) Pulmonary tuberculosis, 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 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 3-27d and e.

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.

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 paragraphs 2-9, 2-10, 2-11, and 4-23, plus *Limitation of motion*.

a. Classes 1, 1A and 3: Less than full strength and range of motion of all joints.

b. Class 2: Any limitation of motion of any joint which might compromise flying safety.

Section VII. EYES AND VISION

4-11. Eyes

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-12, plus the following:

a. Asthenopia of any degree.

b. Chorioretinitis or substantiated history thereof.

c. Coloboma of the choroid or iris.

d. Epiphora.

e. Inflammation of the ocular tract; acute, chronic, or recurrent.

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.

(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) *Field of vision:*

(a) Any demonstrable scotoma, other than physiologic.

(b) Contraction of the field for form of 15° or more in any meridian.

(5) *Near visual acuity*, uncorrected, less than 20/20 (J-1) in each eye.

(6) *Night vision:* Failure to pass test when indicated by history of night blindness.

(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 six cardinal directions.

(b) Esophoria greater than 10 prism diopters.

(c) Exophoria greater than 5 prism diopters.

(d) Hyperphoria greater than 1 prism diopter.

(e) Heterotropia, any degree.

(8) *Power of accommodation* of 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.

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 (Federal stock No. 6515-299-8186), or

(b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic plate Set (Federal stock No. 6515-388-6606), or

(c) Rescinded.

(2) *Depth perception:*

(a) Any error in lines B, C, or D when using the Machine Vision Tester.

(c) Myopia in excess of 0.25 diopter in any meridian.

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 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 or not correctable 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.

★*c. Class 2.* Same as Class 1 except as listed below:

(1) *Color vision:*

(a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set (Federal stock No. 6515-388-6606), or

(b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set (Federal stock No. 6515-388-6606); or

(c) Failure to pass the Farnsworth Lantern Test when used in lieu of (a) or (b) above.

(2) *Distant visual acuity:*

(a) *Control tower operators:* Uncorrected less than 20/50 in each eye or not correctable to 20/20 in each eye.

(b) Rescinded.

(c) *Pilots:* Uncorrected less than 20/100 in each eye or not correctable to 20/20 in each eye.

(3) *Field of vision.* Scotoma, other than physiological unless the pathologic process is healed and which will in no way interfere with flying efficiency or the well-being of the individual.

(4) *Near visual acuity.* Uncorrected less than 20/100 (J-16) in each eye or not correctable to 20/20 in each eye.

(5) *Ocular motility:*

(a) Hyperphoria greater than 1.5 prism.

(b) Failure of the Red Lens Test (suppression or diplopia within 20 inches from the center of the screen in any of the six cardinal directions) until a complete evaluation by a certified ophthalmologist has been forwarded to The Surgeon General for review.

(6) *Refractive error:* No maximum limits prescribed.

d. Class 3:

(1) *Color vision:* Same as Class 2, c(1) above.

(2) *Distant visual acuity:* Uncorrected, less than 20/200 in each eye, not correctable to 20/20 in each eye.

(3) *Near visual acuity, field of vision, night vision, depth perception, power of accommodation, ocular motility:* 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 and 1A. Substantiated history of bilateral renal calculi or of repeated attacks of renal or ureteral colic. Examinees with a history of a single unilateral attack are acceptable, provided—

(1) Excretory urography reveals no congenital or acquired anomaly.

(2) Renal function is normal.

(3) The calculus has been passed and the X-ray shows no evidence of concretion in the kidney, ureter, or bladder.

b. Classes 2 and 3. A history of renal calculus, unless—

(1) Excretory urography reveals no congenital or acquired anomaly.

(2) Renal function is normal.

(3) The calculus has been passed and the X-ray shows no evidence of concretion in the kidney, ureter, or bladder.

Section X. HEAD AND NECK

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; facial paralysis.

Section XI. HEART AND VASCULAR SYSTEM

4-15. Heart and Vascular System

The causes for 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 supra-ventricular arrhythmias such as paroxysmal atrial tachycardia, nodal tachycardia, atrial flutter, and atrial fibrillation.

c. A history of paroxysmal ventricular tachycardia.

d. A history of rheumatic fever, or documented manifestation suggestive of rheumatic fever within the preceding 5 years.

e. Transverse diameter of heart 15 percent or more greater than predicted by appropriate tables.

f. Blood pressure below 90 systolic or 60 diastolic.

g. Unsatisfactory orthostatic tolerance test.

h. Electrocardiographic.

(1) Borderline ECG findings until reviewed by The Surgeon General.

(2) Left bundle branch block.

(3) Persistent premature contractions, except in rated personnel when unassociated with significant heart disease or recurrent tachycardia.

(4) Right bundle branch block unless cardiac evaluation reveals the absence of cardiac disease and that the block is presumably congenital.

(5) Short P-R interval and prolonged QRS time (Wolf-Parkinson-White syndrome) or other short P-R interval syndromes predisposing to paroxysmal arrhythmias. In cases involving Class II or Class III examinations, a complete cardiac evaluation including ECG's will be forwarded to The Surgeon General for review.

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.

★*b. Class 2, Air Traffic Control female. Height below 60 inches or over 72 inches.*

★*c. Class 3:*

(1) *Female. Height below 60 inches or over 72 inches.*

(2) *Male. Height below 62 inches or over 76 inches.*

4-17. Weight

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are—

★*a. Weight for males which does not fall within the limits prescribed in table III, appendix III.*

★*b. Weight for females which does not fall within the limits prescribed in table II, appendix III except that maximum weight may not exceed 180 pounds.*

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 is within the maximum shown in table III, ap-

pendix III, he will be found medically unfit for any flying duty (Classes 1, 1A, 2, and 3) when the medical examiner considers that the excess weight, in relationship to the bony structure and musculature, would adversely affect flying efficiency or endanger the individual's well-being if permitted to continue in flying status.

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 the predicted vital capacity (app. VI).
 - (c) With a value of less than 75 percent of exhaled predicted vital capacity in 1 second (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, normal pulmonary function, no additional lung pathology or other contra-indication to flying is discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

d. Pulmonary tuberculosis:

- (1) *Classes 1 and 1A.* See paragraph 2-25.
- (2) *Classes 2 and 3.* Pulmonary tuberculosis with less than 2 years of inactive disease including 12 months cessation of 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.

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 over a radio communications system.

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 (unless mild and functionally asymptomatic).

c. Anosmia, parosmia, and paresthesia.

Section IX. GENITOURINARY SYSTEM**5-13. Genitourinary System**

Causes of medical unfitness for USMA are the causes listed in paragraphs 2-14 and 2-15, plus the following:

- a. *Atrophy, deformity, or maldevelopment of both testicles.*
- b. *Epispadias.*
- c. *Hypospadias, pronounced.*

d. *Penis.* Amputation or gross deformity.

e. *Phimosis.* Redundant prepuce is not cause for rejection.

f. *Urine.*

(1) *Albuminuria.* Persistent or recurrent of any type regardless of etiology.

(2) *Casts.* Persistent or recurrent regardless of cause.

Section X. HEAD AND NECK**5-14. Head and Neck**

The causes of medical unfitness for USMA are the causes listed in paragraphs 2-18, 2-19, and plus the following:

- a. *Deformities of the skull* in the nature of

depressions, exostoses, etc., which affect the military appearance of the candidate.

b. *Loss or congenital absence of the bony substance of the skull* of any amount.

Section XI. HEART AND VASCULAR SYSTEM**5-15. Heart and Vascular System**

The causes of medical unfitness for USMA are the causes listed in paragraph 2-18, 2-19, and 2-20, plus the following:

a. *Any evidence of organic heart disease.*

b. *Hypertension* evidenced by preponderant readings of 140-mm or more systolic or preponderant diastolic pressure of over 90-mm.

Section XII. HEIGHT, WEIGHT AND BODY BUILD**★5-16. Height**

The causes of medical unfitness for USMA are—

a. Height below 66 inches. However, see special administrative criteria in paragraph 7-14.

b. Height over 80 inches.

5-17. Weight

The causes of medical unfitness for USMA are—

a. *Weight related to age and height* which is below the minimum shown in table I, appendix III.

b. *Weight related to age and height* which is in excess of the maximum shown in table I, appendix III.

5-18. Body Build

The causes of medical unfitness for USMA are the causes listed in paragraph 2-23, plus the following:

Obesity. Even though the candidate's weight is within the maximum shown in table I, appendix III, he will be reported as nonacceptable when the medical examiner considers that the excess weight, in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion or immediate participation in the required physical activities at the USMA.

Section XIII. LUNGS AND CHEST WALL**5-19. Lungs and Chest Wall**

The causes of medical unfitness for USMA are

the causes listed in paragraphs 2-24, 2-25, and 2-26.

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

5-20. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

The causes of medical unfitness for USMA are the causes listed in paragraphs 2-27, 2-28, 2-29, and 2-30, plus the following:

a. *Septal deviation, hypertrophic rhinitis, or other conditions* which result in 50 percent or more obstruction of either airway, or which

interfere with drainage of a sinus on either side.

b. *Speech abnormalities.* Defects and conditions which interfere with the candidate's ability to pronounce and enunciate words correctly and clearly considering the requirements of class recitation and the issuing of commands to large groups of men.

Section XV. NEUROLOGICAL DISORDERS

5-21. Neurological Disorders

The causes of medical unfitness for USMA are the causes listed in paragraph 2-31.

Section XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

5-22. Psychoses, Psychoneuroses, and Personality Disorders

The causes of medical unfitness for USMA are the causes listed in paragraphs 2-32, 2-33, and 2-34, plus the following:

a. *Prominent antisocial tendencies, personality defects, neurotic traits, emotional instabil-*

ity, schizoid tendencies, and other disorders of a similar nature.

b. *Stammering or stuttering* which interferes with the candidate's ability to pronounce and enunciate words correctly and clearly, considering the requirements of class recitation and the issuing of commands to large groups of men.

Section XVII. SKIN AND CELLULAR TISSUES

5-23. Skin and Cellular Tissues

The causes of medical unfitness for USMA are the causes listed in paragraph 2-35, plus the following:

a. *Acne*, moderately severe, or interfering

with wearing of military equipment.

b. *Acne scarring.* Severe.

c. *Bromidrosis.* More than mild.

d. *Vitiligo* or other skin disorders which are disfiguring or unsightly.

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

★5-24. Joints, Spine, Scapulae, Ribs, and Sacroiliac

The causes of medical unfitness for USMA are the causes listed in paragraphs 2-11, 2-36, and 2-37, plus the following:

Defects and diseases of the spine, scapulae, ribs, or sacroiliac joints which interfere with the daily participation in a rigorous physical training or athletic program, with the wearing of military equipment, or which detract from a smart military bearing or appearance.

Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

5-25. Systemic Diseases and Miscellaneous Conditions and Defects

The causes for rejection for USMA are the same as those listed in paragraphs 2-38 and 2-39, plus the following:

Systemic diseases and miscellaneous medi-

cal conditions and physical defects which interfere with the daily participation in a rigorous physical training or athletic program, with the wearing of military equipment, or which detract from a smart military bearing or appearance.

Section XIII. LUNGS AND CHEST WALL

6-25. Tuberculous Lesions

(See also para. 6-26.)

The causes of medical unfitness for military service are—

a. *Pulmonary tuberculosis*, except when (1) or (2) below is applicable.

- (1) Pulmonary tuberculosis of minimal extent, which has been adequately treated and serial chest X-rays indicate that the lesion appears to be fibrous or well calcified and has remained stable for 2 years or more with the individual performing full activity.
- (2) Pulmonary tuberculosis of moderately advanced extent which has been adequately treated and X-rays indicate that the lesions have remained inactive for 5 years or more with the individual performing full activity.

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.

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) Meningitis, tuberculosis.

(2) Pulmonary tuberculosis, tuberculous empyema, and tuberculous pleurisy.

See paragraph 6-25.

- (3) 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.
- (4) Tuberculosis of the larynx, female genitalia, and kidney.
- (5) 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 for rejection are—

a. Allergic manifestations:

- (1) Allergic rhinitis (hay fever) (par. 6-28d).
- (2) Asthma (par. 6-26a).
- (3) Allergic dermatoses (par. 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, chillblain, immersion foot, or trench foot), such as 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 for rejection 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 inclusion 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

Neoplastic conditions of the lymphoid and blood-forming tissues are generally considered as rendering an individual medically unfit for military duty.

6-40. Venereal Disease

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 U.S. 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, 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.

- 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 trait or sickle cell disease.
- c. *Dental.* Paragraph 2-5.
- d. *Ears and hearing.*
 - (1) Paragraphs 2-6 and 2-7.

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

(3) For special forces training and duty. Distant visual acuity of less than 20/70 in one eye and less than 20/200 in the other eye that does not correct to at least 20/20 in one eye.

(4) *Color vision.* Failure to identify red and/or green as projected by the Ophthalmological Projector (Federal Stock No. 6515-388-3600) or Armed Forces Vision Tester (Federal Stock No. 6515-299-8084) equipped with Bausch and Lomb Orthorater, Slide No. 71-21-21. (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 if discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2-27, 2-28, 2-29, and 2-30.

p. Neurological disorders.

(1) Paragraph 2-31.

(2) Active disease of the nervous system of any type.

(3) Craniocerebral injury (para 4-23a (7)).

q. Psychoses, psychoneuroses, and personality disorders.

(1) Paragraphs 2-32, 2-33, and 2-34.

(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 2-35.

s. Spine, scapulae, and sacroiliac joints.

(1) Paragraphs 2-36, 2-37, and *e* above.

(2) *Scoliosis:* lateral deviation of tips of vertebral spinous processes more than one 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 diseases and miscellaneous conditions and defects.

(1) Paragraphs 2-38 and 2-39.

(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. Paragraphs 2-40 and 2-41.

v. Venereal 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—

Section III. MEDICAL FITNESS STANDARDS FOR ARMY SERVICE SCHOOLS

7-5. 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 20-21.

Section IV. MEDICAL FITNESS STANDARDS FOR DIVING TRAINING AND DUTY

7-6. Medical Fitness Standards for Initial Selection for Diving Training

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) Tendency to flatulence.
- (3) Hernia of any variety.
- (4) Operation for relief of intestinal adhesions at any time.
- (5) Gastrointestinal disease of any type.
- (6) Chronic or recurrent gastrointestinal disorder.
- (7) Laparotomy within the preceding 6 months.

b. Blood and blood-forming tissue diseases.

- (1) Paragraph 2-4.
- (2) Sickle cell trait or sickle cell disease.

c. Dental.

- (1) Paragraph 2-5.
- (2) Any oral disease until all infection and any conditions which contribute to recurrence are eradicated.
- (3) Any unserviceable teeth until corrected.

d. Ears and hearing.

- (1) Paragraph 2-6.
- (2) Perforation, marked scarring or thickening of the ear drum.
- (3) Inability to equalize pressure on both sides of the ear drums while under 50 pounds of pressure in a compression chamber.
- (4) Acute or chronic disease of the auditory canal, tympanic membrane, middle or internal ear.
- (5) Hearing acuity level in either ear by audiometric testing (regardless of conversational or whispered voice hearing acuity) which exceeds 15 decibels at any of the frequencies 256, 512, 1024, 2048, or

which exceeds 40 decibels at frequency 4096.

- (6) History of otitis media or otitis externa at any time.

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.
- (3) Loss of any digit of either hand.
- (4) Fracture or history of disease or operation involving any major joint.
- (5) Any limitation of the strength or range of motion of any of the extremities.

g. Eyes and vision.

- (1) Paragraph 2-12.
- (2) Distant visual acuity, uncorrected, of less than 20/40 in each eye.

★(3) *Color vision:*

- (a) Five or more errors in reading the 14 test plates of the Pseudoisochromatic Plate Set (Federal Stock No. 6515-299-8186), or
- (b) Four or more errors in reading the 17 test plates of the Pseudoisochromatic Plate Set (Federal Stock No. 6515-388-6606).
- (4) Abnormalities of any kind noted during ophthalmoscopic examination.

h. Genitourinary system.

- (1) Paragraphs 2-14 and 2-15.
- (2) Chronic or recurrent genitourinary disease or complaints.
- (3) Abnormal findings by urinalysis.

i. Head and neck. Paragraphs 2-16, 2-17, and 4-16h.*j. Heart and vascular system.*

- (1) Paragraphs 2-18, 2-19, and 2-20.
- (2) Varicose veins of any degree.
- (3) Marked or symptomatic hemorrhoids.

- (4) Persistent tachycardia or arrhythmia except of sinus type.
- k. Height:* No special requirement.
- l. Weight.*
- (1) Weight related to height which is below the minimum shown in table IV, appendix III.
 - (2) Weight related to height which is above the maximum shown in table IV, appendix III.
- m. Body build.*
- (1) Paragraph 2-23.
 - (2) Obesity of any degree.
- n. Lungs and chest wall.*
- (1) Paragraphs 2-24, 2-25, and 2-26.
 - (2) History of tuberculosis, asthma, or chronic pulmonary disease, or chest or lung operation at any time.
 - (3) Any pulmonary disease at the time of examination or within 6 months preceding the examination.
 - (4) Inability to hold breath for 60 seconds subsequent to deep breathing.
- o. Mouth, nose, pharynx, larynx, trachea, and esophagus.*
- (1) Paragraphs 2-27, 2-28, 2-29, and 2-30.
 - (2) History of chronic or recurrent sinusitis at any time.
 - (3) Any nasal obstruction or sinus disease at the time of examination.
 - (4) Chronically diseased tonsils until removed.
- p. Neurological disorders.*
- (1) Paragraph 2-31.
 - (2) The special criteria which are outlined in paragraph 4-24 for Class 1 flying duty are also applicable to diving duty.
- q. Psychoses, psychoneuroses, and personality disorders.*
- (1) Paragraphs 2-32, 2-33, and 2-34.
 - (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 2-36 and 2-37.
 - (2) Spondylolysis, spondylolisthesis.
 - (3) Healed fractures or dislocations of the vertebrae.
 - (4) Lumbosacral or sacroiliac strain, or any history of a disabling episode of back pain, especially when associated with significant objective findings.
- t. Systemic diseases and miscellaneous conditions and defects.*
- (1) Paragraphs 2-38 and 2-39.
 - (2) Any severe illness, operation, injury, or defeat of such a nature or of so recent occurrence as to constitute an undue hazard to the individual or compromise safe diving.
- u. Tumors and malignant diseases.* Paragraphs 2-40 and 2-41.
- v. Venereal disease.*
- (1) Active venereal disease or repeated venereal infection.
 - (2) History of clinical or serological evidence of active or latent syphilis within the past 5 years or of cardiovascular or central nervous system involvement at any time.

7-7. Medical Fitness Standards for Retention for Diving Duty

The medical fitness standards contained in paragraph 7-6 apply to all personnel performing diving duty except that divers of long experience and a high degree of efficiency—

a. May be permitted a moderate degree of *overweight* if the individual is otherwise vigorous and active.

b. Must be free from disease of the auditory, cardiovascular, respiratory, genitourinary, and gastrointestinal system.

c. Must maintain their ability to equalize air pressure.

d. Uncorrected visual acuity of not less than 20/40 in the better eye.

considered on an individual basis for an administrative waiver by Headquarters, Department of the Army during the processing of their applications.

b. Individuals being considered for appointment in the Regular Army in Armor, Artillery, or Infantry who are not more than 2 inches below the minimum height requirement of 66 inches *will automatically* be considered for an administrative waiver by Headquarters, Department of the Army during the processing of their applications provided they have outstanding abilities, military records, or educational qualifications.

★7-14. **Height—United States Military Academy**
(See para 5-16.)

The following applies to all male candidates to the United States Military Academy:

Candidates for admission to the United States Military Academy who are below the minimum height of 66 inches *will automatically* be considered for an administrative waiver by Headquarters, Department of the Army during the processing of their cases provided they have exceptional educational qualification, have an outstanding military record, or have demonstrated outstanding abilities.

**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)**

7-17. **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 7-9d.

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.

★7-15. **Vision—Officer Assignment to Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps**

(See para 2-12 and 2-13.)

Individuals being considered for officer assignment to Armor, Artillery, Infantry, Corps of Engineers, Military Intelligence, Military Police Corps, and Signal Corps must meet the following standards: Uncorrected distant visual acuity of any degree that corrects to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error.

7-16. **Weight—Enlistment in WAC for Student Nurse Program and Student Dietician Program and Appointment Therefrom**

The medical fitness standards for initial selection as members of the Women's Army Corps for Training under the Army Student Nurse and the Army Student Dietician Programs, and for commissioning from these programs are set forth in chapter 2 except that the maximum weight standards set forth in table II, appendix III may be exceeded by 10 percent.

- (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) Sick cell preparation (for individuals of susceptible groups).
- (6) Platelet count.
- (7) Fasting blood sugar.

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e. Presence or history of psychiatric illness requiring hospitalization or extensive treatment, or personality disorders including alco-

holism, where either, in the opinion of the examining officer, would make assignment at this specialty inadvisable.

R" or "T" will undergo appropriate medical evaluation to determine the desirability of termination of the modifier. In those instances where the termination of the modifier is not deemed appropriate, the procedure in paragraph 14d(1) and e, AR 635-200 will be followed in the case of enlisted personnel and paragraph 4, AR 135-173 in the case of officer personnel.

b. Individuals whose period of service expires and whose physical profile code is "W" will appear before a medical board to determine if processing as provided in paragraphs 3-3 and 3-4 is indicated.

c. Individuals whose period of service expires and whose physical profile code is "V" will appear before a medical board for processing as provided in paragraph 3-4.

9-10. Assignment Restrictions, or Geographical or Climatic Area Limitations

Paragraph 7-9 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 8-274 (Medical Condition—Physical Profile Record). 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 no assignment limitations associated with a numerical designator "2" except that an individual with a "2" does not meet the medical fitness standards for Ranger training or initial assignment to Airborne and Special Forces.

c. There are significant assignment restrictions, or geographical or climatic area limitations asso-

ciated with a physical profile identified with one or more numerical designator "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 designator "4" when the individual is on active duty.

e. Permanent assignment limitations under peacetime conditions (AR 40-3) normally will be established only by a medical board. Individuals accepted for military service under the provisions of chapter 8 will have assignment limitations established by the AFES profiling officer.

f. Permanent geographical or climatic area assignment limitations may be removed or modified only by a medical board.

g. In every instance each medical condition or physical defect causing an assignment limitation will be identified in nontechnical language.

h. 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 his family. Individuals found fit for military service must be utilized in positions wherein the maximum benefit can be derived from their capabilities. It is desirable that all limitations be confirmed at least once every 3 years, particularly in conjunction with the periodic medical examination, with a view to updating the nature and extent of limitations.

9-11. Responsibility for Personnel Actions

Unit commanders are responsible for necessary personnel actions, including appropriate entries on personnel management records (AR 611-103 and AR 640-203) and the assignment of the individual to military duties commensurate with his recorded physical profile and physical profile code and recorded assignment limitations.

training camp; attendance at summer training camp; continuance in the program; and prior to appointment.

- (21) Separation, resignation, retirement and relief from active duty. (SF 89 is not required in connection with separation examination for immediate reenlistment.)

c. Type B medical examination. A Type B medical examination is required to determine the medical fitness of personnel under the circumstances enumerated below. Standard Form 89 (Report of Medical History) 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 non-designated or nonrated personnel not engaged in the actual control of aircraft, such as aviation medical officers, observers, etc. (SF 89 required for initial selection only.)
- (2) Marine diving including selection, continuance or periodic annual medical examination. (SF 89 required for initial selection only.)
- (3) U.S. Air Force Academy.
- (4) U.S. Air Force Academy Preparatory School.
- (5) U.S. Military Academy.
- (6) U.S. Military Academy Preparatory School.
- (7) U.S. Naval Academy.
- (8) U.S. Naval Academy Preparatory School.

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) One year from date of medical examination to qualify for induction, enlistment, reenlistment, appointment as a commissioned officer or warrant officer, active duty, active duty for training, advanced ROTC, OCS, admission to USMA Preparatory School, and USMA, all flying status, Classes I, IA, II, and III.
- (2) Six months from date of medical examination for separation from active duty, including retirement.
- (3) Three months from date of Secretarial approval for reentry into the Army of members on the TDRL who have been found physically fit.

b. 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 for members of the Ready Reserve (para 10-21) within the past 4 years will be valid for the purpose of qualifying for immediate reenlistment in a Reserve component of Personnel not on active duty, provided there has been no change in the individual's medical condition since his last complete medical examination.

d. Medical examinations conducted at medical facilities of the U.S. Navy or U.S. Air Force or by other U.S. Government or civilian facilities for any of the purposes cited in *a*, *b*, or *c* above will, except for USMA Preparatory School and USMA, be considered acceptable medical examinations if they are of the proper scope prescribed by this chapter and are dated within the required validity periods. USMA qualifying examinations must be conducted at medical facilities of the Armed Forces listed in any service academy catalogs.

Section II. PROCUREMENT MEDICAL EXAMINATIONS

10-18. Procurement Medical Examinations

For administrative procedures pertaining to

procurement medical examinations (para 2-1) conducted at Armed Forces examining and

entrance stations, see AR 601-270. For procedures pertaining to appointment and enlistment in the Reserve components, see AR 140-120

and NGR 27. For procedures pertaining to enrollment in the Army ROTC, see AR 145-120.

Section III. RETENTION, PROMOTION, AND SEPARATION MEDICAL EXAMINATIONS

10-19. General

This section sets forth administrative procedures applicable to retention (including periodic medical examinations), promotion and separation medical examinations (para 3-1).

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 paragraph 7b, AR 135-90, 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 Medical Statement No. 2, DD Form 220 (Active Duty Report), or
- (4) The individual requests a separation examination.

b. An individual on inactive duty training will be given a medical examination if—

- (1) He incurs an injury during such training which may result in disability, or
- (2) He alleges medical unfitness or disability.

c. Evaluation of medical fitness will be based on the medical fitness standards contained in chapter 3.

10-21. Health Records

a. Medical examiners will review the DD Form 722 (Health Record), AR 40-403, of each

examinee whenever an examination is conducted for the purpose of relief from active duty, resignation, retirement, separation from the service or when accomplished in connection with a periodic 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.

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

During mobilization, members of ARNGUS and USAR units who are individually called to active duty or collectively called to active duty with their respective units will undergo a medical examination as prescribed in AR 135-300. Individual members who are medically fit for retention or continuance in the Reserve Components of the Army under the provisions of chapter 3 or chapter 8 are medically fit for mobilization.

10-23. Periodic Medical Examinations

a. *Applicability 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

★APPENDIX II.

TABLES OF ACCEPTABLE AUDIOMETRIC HEARING LEVEL

Table I. Acceptable Audiometric Hearing Level (Present American Standard) for Appointment, Enlistment and Induction

	250	500	1000	2000	3000	4000	6000	8000
	256	512	1024	2048	2896	4096	6144	8192
a. Both ears----- or	(1)	Average of the three (3) frequencies not greater than twenty (20) decibels with no level greater than twenty five (25) decibels.			(2)	50	(2)	(1)
b. Better ear----- Worse ear-----	(1) (1)	15 (1)	15 (1)	15 (1)	(2) (1)	30 (1)	(2) (1)	(1) (1)

Table II. Acceptable Audiometric Hearing Level (Present American Standard) for Army Aviation

	250	500	1000	2000	3000	4000	6000	8000
	256	512	1024	2048	2896	4096	6144	8192
1 and 1A both ears-----	(1)	15	15	15	(2)	40	(2)	(1)
2 better ear----- worse ear-----	(1) (1)	20 20	20 40	20 40	(2) (2)	(1) (1)	(2) (2)	(1) (1)
3 better ear-----	(1)	20	20	40	(2)	(1)	(2)	(1)

Table III. Acceptable Audiometric Hearing Level (Present American Standard) for Admission to the U.S. Military Academy

	250	500	1000	2000	3000	4000	6000	8000
	256	512	1024	2048	2896	4096	6144	8192
Both ears-----	(1)	15	15	15	(2)	40	(2)	(1)

¹ No requirement.
² Not yet standardized.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
45 A B C D	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	Identify tests used and record results. Items A and D are not routinely required for chargeable accessions; only if indicated.	
46	✓	✓	Note film size, number, date and place taken and findings. A report of chest X-ray accomplished within the preceding 12 months may, at the discretion of the examining physician, be accepted in lieu of a current chest X-ray. Note facility, place and date taken, film size, number, wet or dry reading and findings. Reading must be by radiologist, or internist experienced in radiology.	14 x 17 film no. 54321 Letterman General Hospital, San Francisco, Calif., 8 December 1964, dry reading, negative.
47	✓	✓	★Kahn, Wasserman, VDRL, or cardiolipin microflocculation tests recorded as negative or positive. On positive reports note date, place and titre. Serology not required for periodic examination.	Cardiolipin. Microflocculation. Negative. Normal. Abnormal—see attached report.
48	(*)	✓	*Required for retirement or if age 40 or over; also if indicated. Representative samples of all leads (including precordial leads) properly mounted and identified on Standard Form 520 (EKG report) will be attached to the original of SF 88. Standard Form 520 should be attached to all copies of SF 88. The interpretation of the EKG will be entered in item 48 (or 73 if necessary) on all copies of SF 88.	Normal. Abnormal—see attached report.
49	—	—		
50	(*)	(*)	*Only if indicated. Identify test(s) and record results.	
51	✓	✓	Record in inches to the nearest quarter inch, (without shoes).	71½.
52	✓	✓	Record in pounds to the nearest whole pound, (without clothing and shoes).	164.
53	✓	✓	Record as black, blond, brown, gray or red.	Brown.
54	✓	✓	Record as blue, brown, gray or green.	Blue.
55	✓	✓	Enter X in appropriate space. If obese, enter X in two spaces as appropriate. For definition of obesity see appendix I.	
56	(*)	✓	*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6°.
57 A, B and C	(*)	✓	Record sitting blood pressure for all examinations. *Only if indicated by abnormal findings in A, i.e., if sitting blood pressure is 140/90 or more for individuals below age 35, or 150/90 for those age 35 and above. Any abnormal reading should be rechecked by recording blood pressure readings twice a day (morning and afternoon) for 3 consecutive days.	110/76
58 A	✓	✓	Record for all examinees.	
B, C, D and E	(*)	✓	*Record only if indicated by abnormal findings in 58A, i.e., if A is 100 or more, or below 50. If either D or E is 100 or more, or less than 50, record pulse twice a day (morning and afternoon) for 3 days and enter in item 73. Also record average pulse in item 73.	
59	✓	✓	Record in terms of the English Snellen Linear System (20/20, 20/30, etc.) of the uncorrected vision of each	20/100 corr. to 20/20. 20/50 corr. to 20/20.

Item SF 88	Types of examinations		Explanatory notes	Model entries
	A	B		
60	(*)	✓	<p>eye. If uncorrected vision of either eye is less than 20/20, entry will be made of the corrected vision of each eye.</p> <p>★Refraction required for induction enlistment and appointment if <i>corrected</i> vision is less than the minimum visual standards stated in paragraph 2-13a, or if deemed appropriate by the examiner regardless of visual acuity.</p> <p>Cycloplegic required for initial selection for service academies and preparatory schools, diving and Class I, IA and II flying—thereafter only if indicated. The word “manifest” or “cycloplegic,” whichever is applicable, will be entered after “refraction”.</p> <p>An emmetropic eye will be indicated by plano or 0. For corrective lens, record refractive value.</p>	<p>By -1.50 S+0.25 CX 05.</p> <p>By -1.50 S+0.25 CX 175.</p>
61	✓	✓	<p>Record results in terms of reduced Snellen. Whenever the uncorrected vision is less than normal (20/20) an entry will be made of the corrected vision for each eye and lens value after the word “by”.</p>	<p>20/40 corr. to 20/20 by same.</p> <p>20/40 corr. to 20/20 by +0.50.</p>
62	—	✓	<p>Identify the test used, i.e., either the Maddox Rod Test or the Armed Forces Vision Tester, and record results. Prism Div and PD not required. Not required for dependents.</p>	<p>Armed Forces Vision Tester.</p> <p>ES° 4 EX° 0 R.H.</p> <p>0 L.H. 0</p> <p>Prism Div. _____CT</p> <p>Ortho</p> <p>PC 35 PD _____</p> <p>Right 10.0 Left 9.5.</p>
63	—	✓	<p>Record values without using the word “diopters” or symbols.</p>	<p>Pseudoisochromatic Plate Set.</p> <p>Fail 6/17</p> <p>Passed red/green.</p>
64	✓	✓	<p>Required only as initial test and subsequently only when indicated. Not required for dependents. Record results in terms of the test used, pass or fail, and number of plates missed over the number of plates in the test.</p> <p>If examinee fails Pseudoisochromatic Test, he will be tested for red/green color vision and results recorded as “passed” or “failed red/green.”</p>	<p>Howard-Dolman 25.</p> <p>Verhoeff passes.</p>
65	—	✓	<p>Identify test used and record results for uncorrected and corrected. Enter dash in corrected space if applicable. Score is entered for Howard-Dolman; passes or fails is used for Verhoeff.</p>	<p>Confrontation test: Normal, full.</p>
66	—	✓	<p>Identify test used and results. If a visual field defect is found or suspected in the confrontation test, a more exact perimetric is made using the perimeter and tangent screen. Findings are recorded on visual chart and described in item 73. Copy of chart must accompany original SF 88.</p>	<p>NIBH.</p>
67	—	(*)	<p>*Only if indicated by history, record results. If not indicated enter NIBH.</p>	<p>Normal.</p>
68	—	✓	<p>Record test results and describe all abnormalities.</p>	<p>Normal.</p>
69	(*)	(*)	<p>*Only if indicated.</p> <p>Tonometry on all personnel age 40 and over.</p> <p>Record results numerically in millimeters of mercury of intraocular pressure. Describe any abnormalities; continue in item 73 if necessary.</p>	<p>O.D. 18.9.</p> <p>O.S. 17.3.</p>
70	—	—	<p>Not required. Enter dash in each space.</p>	
71	✓	✓	<p>Test and record results at 500, 1000, 2000, and 4000 cycles except for service academies for which 3000 and 6000 will also be tested and results recorded.</p>	

s/s C23

Feb 4, 1969

C 18, AR 40-501
3-37

- (2) *Asthma*. See paragraph 3-25a.
- (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. Conditions and defects, individually or in combination, not elsewhere provided in this chapter, if—

- (1) The individual is precluded from a reasonable fulfillment of the purpose of his employment in the military service, or
- (2) The individual's health or well-being

would be compromised if he were to remain in the military service, or

- (3) The individual's retention in the military service would prejudice the best interests of the Government.

Questionable cases will be referred to physical evaluation boards for a determination of fitness.

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 normally render an individual unfit for further military service.

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. VENEREAL DISEASES

3-40. Venereal Diseases

- a. Symptomatic neurosyphilis* in any form.
- b. Complications or residuals of venereal dis-*

ease of such chronicity or degree that the individual is incapable of performing useful duty.

S/S Ch 22 June 19, 1968

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 procurement 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.

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 authority 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

MEDICAL FITNESS STANDARDS FOR APPOINTMENT, ENLISTMENT, AND INDUCTION (Short Title: PROCUREMENT MEDICAL FITNESS STANDARDS)

Section I. GENERAL

2-1. Scope

This chapter sets forth the medical conditions and physical defects which are causes for rejection for military service in peacetime. For medical fitness standards during mobilization, see chapter 6.

★2-2. Applicability

These standards apply to—

a. Male and female applicants for appointment as commissioned or warrant officers, or for enlistment in the U.S. Army, regardless of component.

b. Applicants for the Advanced Course Army ROTC, and other personnel procurement pro-

grams other than induction, where these standards are prescribed.

c. Registrants who undergo preinduction or induction medical examination pursuant to the Universal Military Training and Service Act (50 USC, Supplement IV, Appendix 454, as amended) except medical and dental registrants who are to be evaluated under chapter 8.

d. Male and female applicants for enlistment in the U.S. Air Force or Air Force Reserve.

e. Male applicants for enlistment or reenlistment in the U.S. Navy or Naval Reserve.

f. "Chargeable accessions" for enlistment in the U.S. Marine Corps or Marine Corps Reserve. See paragraph 12d, AR 601-270.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

2-3. Abdominal Organs and Gastrointestinal System

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

a. *Cholecystectomy*, sequelae of, such as post-operative stricture of the common bile duct, reforming of stones in hepatic or common bile ducts, or incisional hernia, or post-cholecystectomy syndrome when symptoms are so severe as to interfere with normal performance of duty.

b. *Cholecystitis*, acute or chronic, with or without cholelithiasis, if diagnosis is confirmed by usual laboratory procedures or authentic medical records.

c. *Cirrhosis* regardless of the absence of manifestations such as jaundice, ascites or known esophageal varices, abnormal liver function tests with or without history of chronic alcoholism.

d. *Fistula* in ano.

e. *Gastritis*, chronic hypertrophic, severe.

f. *Hemorrhoids*.

- (1) External hemorrhoids producing marked symptoms.

- (2) Internal hemorrhoids, if large or accompanied with hemorrhage or protruding intermittently or constantly.

g. *Hepatitis* within the preceding 6 months, or persistence of symptoms after a reasonable period of time with objective evidence of impairment of liver function.

h. *Hernia*:

- (1) Hernia other than small asymptomatic umbilical or hiatal.

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

i. *Intestinal obstruction* or authenticated history of more than one episode, if either occurred during the preceding 5 years, or if resulting condition remains which produces significant symptoms or requires treatment.

j. *Megacolon* of more than minimal degree, *diverticulitis*, *regional enteritis*, and *ulcerative colitis*. *Irritable colon* of more than moderate degree.

k. *Pancreas*, acute or chronic disease of, if proven by laboratory tests, or authenticated medical records.

l. Rectum, stricture or prolapse of.

m. Resection, gastric or of bowel; or gastroenterostomy; however minimal intestinal resection in infancy or childhood (*for example*: for intussusception or pyloric stenosis) is acceptable if the individual has been asymptomatic since the resection and if surgical consultation (to include upper and lower gastrointestinal series) gives complete clearance.

n. Scars.

- (1) Scars, abdominal, regardless of cause, which show hernial bulging or which interfere with movements.
- (2) Scar pain associated with disturbance of function of abdominal wall or contained viscera.

o. Sinuses of the abdominal wall.

p. Splenectomy, except when accomplished for the following:

- (1) Trauma.
- (2) Causes unrelated to diseases of the spleen.
- (3) Hereditary spherocytosis.
- (4) Disease involving the spleen when followed by correction of the condition for a period of at least 2 years.

q. Tumors. See paragraphs 2-40 and 2-41.

r. Ulcer:

- (1) Ulcer of the stomach or duodenum, if diagnosis is confirmed by X-ray examination, or authenticated history thereof.
- (2) Authentic history of surgical operation(s) for gastric or duodenal ulcer.

s. Other congenital or acquired abnormalities and defects which preclude satisfactory performance of military duty or which 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 condition and basic cause are corrected.
- (2) Deficiency anemia, not controlled by medication.
- (3) Abnormal destruction of RBC's: Hemolytic anemia.
- (4) Faulty RBC construction: Hereditary hemolytic anemia, thalassemia and sickle cell anemia.
- (5) Myelophthitic anemia: Myelomatosis, leukemia, Hodgkin's disease.

(6) Primary refractory anemia: Aplastic anemia, DiGuglielmo's syndrome.

b. Hemorrhagic states:

- (1) Due to changes in coagulation system (hemophilia, etc.).
- (2) Due to platelet deficiency.
- (3) Due to vascular instability.

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

d. Myeloproliferative disease (other than leukemia):

- (1) Myelofibrosis.
- (2) Megakaryocytic myelosis.
- (3) Polycythemia vera.

e. Splenomegaly until the cause is remedied.

f. Thromboembolic disease except for acute, nonrecurrent conditions.

ous, asymptomatic, less than 3 centimeters in diameter, with no general enlargement of the uterus. See also paragraphs 2-40 and 2-41.

i. Oophoritis, acute or chronic.

j. Ovarian cysts, persistent and considered to be of clinical significance.

k. Pregnancy.

l. Salpingitis, acute or chronic.

m. Testicle(s). (See also para 2-40 and 2-41.)

(1) Absence or nondescent of both testicles.

(2) Undiagnosed enlargement or mass of testicle or epididymis.

★(3) Undescended testicle.

n. Urethritis, acute or chronic, other than gonorrheal urethritis without complications.

o. 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.

p. Vagina.

(1) Congenital abnormalities or severe lacerations of the vagina.

(2) Vaginitis, acute or chronic, manifested by leukorrhea.

q. Varicocele or hydrocele, if large or painful.

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 complications (adhesions, disfiguring scars, etc.) residual to surgical correction of these conditions.

2-15. Urinary System

(See para 2-8, 2-40, and 2-41.)

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

a. Albuminuria if persistent or recurrent in-

cluding so-called orthostatic or functional albuminuria.

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

c. Enuresis determine to be a symptom of an organic defect not amenable to treatment. (See also para 2-34c.)

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

e. Hematuria, cylindruria, or other findings indicative of renal tract disease.

f. Incontinence of urine.

g. 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) Hydronephrosis or pyonephrosis.

(5) Nephritis, acute or chronic.

(6) Pyelitis, pyelonephritis.

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.

k. 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.

l. Skeneitis.

m. Urethra.

(1) Stricture of the urethra.

(2) Urethritis, acute or chronic, other than gonorrheal urethritis without complications.

n. Urinary fistula.

o. Other diseases and defects of the urinary system which obviously preclude satisfactory

performance of duty or which 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 which 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 paragraph 2-31.

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

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

d. Depressed fractures near central sulcus with or without convulsive seizures.

e. Loss or congenital absence of the bony substance of the skull except that The Surgeon General may find individuals acceptable when—

- ★(1) The area does not exceed 2.5 centimeters square, and does not overlie the motor cortex or a dural sinus.
- (2) There is no evidence of alteration of brain function in any of its several spheres (intelligence, judgment, perception, behavior, motor control, sensory function, etc.).
- (3) There is no evidence of bone degeneration, disease, or other complications of such a defect.

f. Unsightly deformities, such as large birthmarks, large hairy moles, extensive scars, and mutilations due to injuries or surgical operations; ulcerations; fistulae, atrophy, or paralysis of part of the face or head.

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-ray is not considered to meet this 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, of any type.

d. Healed tuberculosis lymph nodes when extensive in number or densely calcified.

e. 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 so disfiguring as to make the individual objectionable in common social relationships.

f. Spastic contraction of the muscles of the neck, persistent, and chronic.

g. Tumor of thyroid or other structures of the neck. See paragraphs 2-40 and 2-41.

Section XI. HEART AND VASCULAR SYSTEM

2-18. Heart

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

a. All organic valvular diseases of the heart, including those improved by surgical procedures.

b. Coronary artery disease or myocardial in-

farction, old or recent or true angina pectoris, at any time.

c. Electrocardiographic evidence of major arrhythmias such as—

- (1) Atrial tachycardia, flutter, or fibrillation, ventricular tachycardia or fibrillation.

- (2) Conduction defects such as first degree atrio-ventricular block and right bundle branch block. (These conditions occurring as isolated findings are not unfitting when cardiac evaluation reveals no cardiac disease.)
- (3) Left bundle branch block, 2d and 3d degree AV block.
- (4) Unequivocal electrocardiographic evidence of old or recent myocardial infarction; coronary insufficiency at rest or after stress; or evidence of heart muscle disease.

d. Hypertrophy or dilatation of the heart as evidenced by clinical examination or roentgenographic examination and supported by electrocardiographic examination. Care should be taken to distinguish abnormal enlargement from increased diastolic filling as seen in the well conditioned subject with a sinus bradycardia. Cases of enlarged heart by X-ray not supported by electrocardiographic examination will be forwarded to The Surgeon General for evaluation.

e. Myocardial insufficiency (congestive circulatory failure, cardiac decompensation) obvious or covert, regardless of cause.

f. Paroxysmal tachycardia within the preceding 5 years, or at any time if recurrent or disabling or if associated with electrocardiographic evidence of accelerated A-V conduction (Wolff-Parkinson-White).

g. Pericarditis; endocarditis; or myocarditis, history or finding of, except for a history of a single acute idiopathic or coxsackie pericarditis with no residuals.

h. Tachycardia persistent with a resting pulse rate of 100 or more, regardless of cause.

2-19. Vascular System

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

a. Congenital or acquired lesions of the aorta and major vessels, such as syphilitic aortitis, demonstrable atherosclerosis which interferes with circulation, congenital or acquired dilatation of the aorta (especially if associated with

other features of Marfan's syndrome), and pronounced dilatation of the main pulmonary artery.

b. Hypertension evidenced by preponderant blood pressure readings of 150-mm or more systolic in an individual over 35 years of age or preponderant readings of 140-mm or more systolic in an individual 35 years of age or less. Preponderant diastolic pressure over 90-mm diastolic is cause for rejection at any age.

c. Marked circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, severe peripheral vasomotor disturbances and sympathicotonia.

d. Peripheral vascular disease including Raynaud's phenomena, Buerger's disease (thromboangiitis obliterans), erythromelalgia, arteriosclerotic and diabetic vascular diseases. Special tests will be employed in doubtful cases.

e. Thrombophlebitis.

- (1) History of thrombophlebitis with persistent thrombus or evidence of circulatory obstruction or deep venous incompetence in the involved veins.
- (2) Recurrent thrombophlebitis.

f. Varicose veins, if more than mild, or if associated with edema, skin ulceration, or residual scars from ulceration.

2-20. Miscellaneous

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

a. Aneurysm of the heart or major vessel, congenital or acquired.

b. History and evidence of a congenital abnormality which has been treated by surgery but with residual abnormalities or complications, for example: Patent ductus arteriosus with residual cardiac enlargement or pulmonary hypertension; resection of a coarctation of the aorta without a graft when there are other cardiac abnormalities or complications; closure of a secundum type atrial septal defect when there are residual abnormalities or complications.

c. Major congenital abnormalities and defects of the heart and vessels unless satisfactorily

corrected without residuals or complications. Uncomplicated dextrocardia and other minor asymptomatic anomalies are acceptable.

d. *Substantiated history of rheumatic fever*

or chorea within the previous 2 years, recurrent attacks of rheumatic fever or chorea at any time, or with evidence of residual cardiac damage.

Section XII. HEIGHT, WEIGHT, AND BODY BUILD

2-21. Height

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

a. *For appointment.*

(1) *Men.* Regular Army—Height below 66 inches or over 78 inches. However, see special administrative criteria in paragraph 7-13.

Other—Height below 60 inches or over 78 inches.

(2) *Women.* Height below 58 inches or over 72 inches.

b. *For enlistment and induction.*

(1) *Men.* Height below 60 inches or over 78 inches.

(2) *Women.* Height below 58 inches or over 72 inches.

2-22. Weight

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

a. *Weight related to height* which is below the minimum shown in table I, appendix III for men and table II, appendix III for women.

b. *Weight related to age and height* which is in excess of the maximum shown in table I, ap-

pendix III for men and table II, appendix III for women. See chapter 7 for special requirements pertaining to maximum weight standards applicable to women enlisting for and commissioned from Army Student Nurse and Army Student Dietician Programs.

2-23. Body Build

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

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

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

c. *Evidences of congenital asthenia* (slender bones; weak thorax; visceroptosis; severe, chronic constipation; or "drop heart" if marked in degree).

d. *Obesity.* Even though the individual's weight is within the maximum shown in table I or II, as appropriate, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's weight in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion of prescribed training.

Section XIII. LUNGS AND CHEST WALL

2-24. General

The following conditions are causes for rejection for appointment, enlistment, and induction until further study indicates recovery without disqualifying sequelae:

a. *Abnormal elevation of the diaphragm* on either side.

b. *Acute abscess* of the lung.

c. *Acute bronchitis* until the condition is cured.

d. *Acute fibrinous pleurisy*, associated with acute nontuberculous pulmonary infection.

e. *Acute mycotic disease* of the lung such as coccidioidomycosis and histoplasmosis.

f. *Acute nontuberculous pneumonia.*

g. *Foreign body in trachea or bronchus.*

plaint without symptoms and objective signs is required.

c. Deviation or curvature of spine from normal alignment, structure, or function (scoliosis, kyphosis, or lordosis, spina bifida occulta, spondylolysis, etc.), if—

- (1) Mobility and weight-bearing power is poor.
- (2) More than moderate restriction of normal physical activities is required.
- (3) Of such a nature as to prevent the individual from following a *physically active vocation* in civilian life.
- (4) Of a degree which will interfere with the wearing of a uniform or military equipment.
- (5) Symptomatic, associated with positive physical finding(s) demonstrable by X-ray.

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

e. Granulomatous diseases either active or healed.

f. Healed fracture of the spine or pelvic bones

with associated symptoms which have prevented the individual from following a *physically active vocation* in civilian life or which preclude the satisfactory performance of military duty.

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

★*h. Spondylolysis or spondylolisthesis* that is symptomatic or is likely to interfere with performance of duty or is likely to require assignment limitations.

2-37. Scapulae, Clavicles, and Ribs

(See also 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 of rib, sternum, clavicle, scapula, or vertebra.

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

Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

2-38. Systemic Diseases

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

a. Dermatomyositis.

b. Lupus erythematosus; acute, subacute, or chronic.

c. Progressive systemic sclerosis.

d. Reiter's Disease.

e. Sarcoidosis.

f. Scleroderma, diffuse type.

g. Tuberculosis:

- (1) Active tuberculosis in any form or location.
- (2) Pulmonary tuberculosis. See paragraph 2-25.

(3) Confirmed history of tuberculosis of a bone or joint, genitourinary organs, intestines, peritoneum or mesenteric glands at any time.

(4) Meningeal tuberculosis; disseminated tuberculosis.

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 paragraph 2-28.

(2) Asthma. See paragraph 2-26*b*.

(3) Allergic dermatoses. See paragraph 2-35.

(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 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 examinee medically unacceptable.

e. Cold injury, residuals of, (example: frostbite, chilblain, immersion foot, or trench foot) such as 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, trichlorethylene, 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 preclude the satisfactory performance of military duty.

Section XX. TUMORS AND MALIGNANT DISEASES

2-40. Benign Tumors

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

a. Any tumor of the—

- (1) Auditory canal, if obstructive.
- (2) Eye or orbit (see also para 2-12a(6)).
- (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 or original lesion.

b. *Benign tumors of the abdominal wall* if sufficiently large to interfere with military duty.

c. *Benign tumors of bone* likely to continue to enlarge, be subjected to trauma during military service, or show malignant potential.

d. *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.

e. *Tongue, benign tumor of*, if it interferes with function.

f. *Breast, thoracic contents, or chest wall*, tumors, of, other than fibromata lipomata, and inclusion or sebaceous cysts which do not interfere with military duty.

f. *For tumors of the internal or external female genitalia* see paragraph 2-14h.

2-41. Malignant Diseases and Tumors

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

a. *Leukemia*, acute or chronic.

★CHAPTER 3

**MEDICAL FITNESS STANDARD FOR RETENTION, PROMOTION
AND SEPARATION INCLUDING RETIREMENT****(Short Title: RETENTION MEDICAL FITNESS STANDARDS)****Section I. GENERAL****3-1. Scope**

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

3-2. Applicability

a. These standards apply to the following individuals:

- (1) Those on active duty including active duty for training.
- (2) Members of the Reserve components not on active duty except members of the Retired Reserve.
- (3) Members on the temporary disability retired list.

b. These standards do not apply in determining an individual's medical fitness for Army aviation, airborne, marine diving, ranger or other assignments or duties having special medical fitness standards for retention therein.

3-3. Policies

a. Normally, members with conditions listed in this chapter will be considered unfit by reason of physical disability; 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 must be decided upon the relevant facts and a determination of fitness or unfitness must be made dependent upon the abilities of the member to perform the duties of his office, grade, rank, or rating in such a manner as to reasonably fulfill the purpose of his employment in the military service.

b. The various medical conditions and physical defects which may render a member unfit for military duty by reason of physical disability are not necessarily all listed in this chapter. Further, an individual may be unfit because of physical dis-

ability 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 normally makes an individual unfit because of physical disability if—

- (1) The individual is precluded from a reasonable fulfillment of the purpose of his employment in the military service, or
- (2) The individual's health or well-being would be compromised if he were to remain in the military service, or
- (3) The individual's retention in the military service would prejudice the best interests of the Government

c. A member will not be declared unfit for military service because of impairments which were known to exist at time of his acceptance for military service, and which have remained essentially the same in degree of severity since acceptance and have not interfered with his 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 (chapter 10, AR 635-40 (to be published) AR 140-120, and NGR 27) will not necessarily be declared unfit because of physical disability solely because of the defect which caused his special status, when the impairment has remained essentially unchanged and has not interfered with his performance of duty. When his separation or retirement is authorized or required for some other reason, this impairment, like any other, will be evaluated in connection with his processing for separation or retirement.

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 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.

h. Latent impairments will be accorded appropriate consideration both in determining unfitness because of physical disability and in accessing the degree of disability.

i. Every effort will be made to accurately record the physical condition of each member throughout his Army career. A member undergoing examination and evaluation incident to retirement, however, will be judged on actual existing impairments and disabilities with due consideration for latent impairments. It is important, therefore, that all medical conditions and physical defects which are present, be recorded, no matter how minor they may appear. Performance of duty despite an impairment will not be considered presumptive evidence of physical fitness.

3-4. Disposition of Members Who May be Unfit Because of Physical Disability

a. Members who are believed to be unfit because of physical disability, or who have one of the conditions listed in this chapter, will be processed as prescribed in AR 40-3 and AR 635-40 (to be pub-

lished) to determine their eligibility for physical disability benefits under chapter 61, title 10, United States Code. In certain instances, continuance on active duty despite unfitness because of physical disability may be appropriate as indicated below. 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 be retained on active duty and their disability separation or retirement processing deferred for the duration of the mobilization or as directed by the Secretary of the Army. During mobilization, those who are 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 do not meet retention medical fitness standards (mobilization medical fitness standards when these are in effect) will be advised that they may apply for continuance on active duty as provided in chapter 10, AR 635-40 (to be published). Medical board action and purely medical criteria (other than medical fitness standards) to be considered in these cases are contained in AR 40-2. Members having between 18 and 20 years of service creditable for retirement who request continuance on active duty will not be processed for physical disability separation or retirement without approval of Headquarters, Department of the Army, despite the recommendation of a medical board to the contrary.

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 25-3, NGR 27, or NGR 62 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 Reserve components who may be unfit because of physical 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

d. History of repeated hemorrhage from nasopharynx unless 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

4-23. Neurological Disorders

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-31 and 4-14, plus the following:

a. Classes 1 and 1A.

- (1) *A history of infectious meningitis or meningismus* unless it occurred at least 1 year before the examination and the examinee has been without residuals or sequelae for the period beginning 1 month following recovery from the acute phase of the disease.
- (2) *A history of encephalitis*, unless it occurred at least 10 years before the examination, the examinee has been without residuals or sequelae for the period beginning 6 months following recovery from the acute phase of the disease, and current EEG findings are normal.
- (3) *Atrophy of an isolated muscle or muscle group*, unless involvement is slight, non-progressive and of such a nature so as to not interfere with prolonged normal function in any practical manner, as determined by careful history and examination. In addition the onset must have been at least 5 years before the examination.
- (4) *A history of fractured skull*, unless unaccompanied by disqualifying sequelae for 1 year with negative physical and laboratory data at the time of the examination.
- (5) *Any other organic disease of the central or peripheral nervous system* or definite history of such disease.
- (6) *A history of polyneuritis*, unless it occurred at least 5 years prior to the examination and without present symptoms or incapacity.
- (7) *Craniocerebral injury*, defined as any trauma to the head, with—
 - (a) Unconsciousness, unless shorter than

2 hours in duration and if multiple episodes, shorter than 2 hours combined duration.

- (b) Amnesia, unless shorter than 4 hours in duration.
- (c) Change in personality or deterioration of intellect.
- (d) Craniotomy.
- (e) Depressed fracture or absence of bony substance of the skull.
- (f) Focal neurological signs such a paralysis, weakness, disturbance of sensation, or convulsive seizure.
- (g) Post-traumatic headache, unless shorter than 3 months in duration.

Examinees with complications other than those listed above, are not necessarily acceptable. In general the decision must be based upon the following: The duration of symptoms such as unconsciousness or amnesia; the time elapsed since the injury; and the clinical and laboratory findings; including X-ray of the skull, electroencephalography, caloric study of vestibular function, report of the attending physician, and complete neurological examination. Examinees with a history of a single brief period of unconsciousness or amnesia (less than 15 minutes) because of head injury are acceptable at any time, but special circumstances may indicate need for a complete neurological survey or delay of 1 year from the time of the accident to permit questionable sequelae to develop or to recede. Any individual with unconsciousness or amnesia or more than 15 minutes duration at any time should not be accepted within a year of the injury and then only after a detailed neurological study.

- (8) *Epilepsy or convulsive disorder* of any type other than during febrile illnesses of childhood.
- (9) *Isolated neuritis* occurring within the 5 years preceding the examination, unless the cause is definitely determined and found to be no basis for future concern and examination reveals no or only minimal residuals considered inconsequential from the standpoint of duty contemplated.
- (10) *Migraine or migrainous type of headache* occurring repeatedly and of sufficient intensity as to incapacitate temporarily the examinee for his usual pursuits or to require regular medications.
- (11) *Poliomyelitis*, unless it occurred over 1 year prior to the date of the examination and shows no residuals.

b. Classes 2 and 3.

- (1) *Active disease of the nervous system* of any type. Upon arrest of the active disease, individual evaluation will be made

as to qualification for return to flying duty. Questionable cases will be referred to higher headquarters with complete documentation for final decision.

- (2) *Craniocerebral injury* until the provisions outlined in a(7) above are fulfilled. If there is reason to believe that focal brain injury or dural damage has occurred, seizures may follow and suspension should be for at least 1 year following the injury. Such damage may be expected when depressed fractures, penetrating injuries, amnesia lasting several hours, prolonged unconsciousness, or focal neurological findings have occurred. A craniotomy for any cause should be followed likewise by a period of at least 1 year of ground duty only. Should convulsions or other serious sequelae or complications appear, suspension from flying must be indefinite.
- (3) *Epilepsy or convulsive disorder* of any type rather than during acute febrile illness of childhood.

Section XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

★4-24. Psychoses, Psychoneuroses, and Personality Disorders

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3, are the causes listed in paragraphs 2-32, 2-33, 2-34, and 4-27d plus the following:

a. 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.

b. Character behavior disorders. See SR 40-1025-2.

c. Enuresis after age 10, repeated.

d. Excessive use of alcohol or drugs which has interfered with the performance of duty.

e. Fear of flying when a manifestation of a psychiatric illness. Refusal to fly or fear of flying

not due to a psychiatric illness is an administrative problem.

f. Habit spasm, stammering or stuttering of any degree after age 10.

g. History of psychosis or attempted suicide at any time.

h. Insomnia, severe and prolonged.

i. Night terrors, severe, repeated.

j. Obsessions, compulsions, aerophobia, and phobias which influence behavior materially.

k. Psychogenic amnesia at any time.

l. Psychoneurosis (see SR 40-1025-2) when more than mild and incapacitating to any degree at any time.

m. Somnambulism, multiple (2 or more) instances after age of 10 or an episode within 1 year preceding the examination.

n. Vasomotor instability.

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 paragraph 2-35.

Section IX. GENITOURINARY SYSTEM

5-13. Genitourinary System

Causes of medical unfitness for USMA are the causes listed in paragraphs 2-14 and 2-15, plus the following:

- a. *Atrophy, deformity, or maldevelopment of both testicles.*
- b. *Epispadias.*
- c. *Hypospadias, pronounced.*

d. *Penis.* Amputation or gross deformity.

e. *Phimosis.* Redundant prepuce is not cause for rejection.

f. *Urine.*

- (1) *Albuminuria.* Persistent or recurrent of any type regardless of etiology.
- (2) *Casts.* Persistent or recurrent regardless of cause.

Section X. HEAD AND NECK

5-14. Head and Neck

The causes of medical unfitness for USMA are the causes listed in paragraphs 2-16 and 2-17, plus the following:

a. *Deformities of the skull* in the nature of depressions, exostoses, etc., which affect the military appearance of the candidate.

b. *Loss or congenital absence of the bony substance of the skull* of any amount.

Section XI. HEART AND VASCULAR SYSTEM

5-15. Heart and Vascular System

The causes of medical unfitness for USMA are the causes listed in paragraph 2-18, 2-19, and 2-20, plus the following:

a. *Any evidence of organic heart disease.*

★b. *Hypertension* evidenced by preponderant readings of 140-mm or more systolic or preponderant diastolic pressure of over 90-mm.

Section XII. HEIGHT, WEIGHT AND BODY BUILD

5-16. Height

The causes of medical unfitness for USMA are—

- a. *Height below 66 inches.* However, see special administrative criteria in paragraph 7-14.
- b. *Height over 78 inches.* However, see special administrative criteria in paragraph 7-14.

5-17. Weight

The causes of medical unfitness for USMA are—

- a. *Weight related to age and height* which is below the minimum shown in table I, appendix III.
- b. *Weight related to age and height* which is

in excess of the maximum shown in table I, appendix III.

5-18. Body Build

The causes of medical unfitness for USMA are the causes listed in paragraph 2-23, plus the following:

Obesity. Even though the candidate's weight is within the maximum shown in table I, appendix III, he will be reported as nonacceptable when the medical examiner considers that the excess weight, in relation to the bony structure and musculature, constitutes obesity of such a degree as to interfere with the satisfactory completion or immediate participation in the required physical activities at the USMA.

Section XIII. LUNGS AND CHEST WALL

5-19. Lungs and Chest Wall

The causes of medical unfitness for USMA

are the causes listed in paragraphs 2-24, 2-25, and 2-26.

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

5-20. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

The causes of medical unfitness for USMA are the causes listed in paragraphs 2-27, 2-28, 2-29, and 2-30, plus the following:

a. *Septal deviation, hypertrophic rhinitis, or other conditions* which result in 50 percent or more obstruction of either airway, or which

interfere with drainage of a sinus on either side.

b. *Speech abnormalities.* Defects and conditions which interfere with the candidate's ability to pronounce and enunciate words correctly and clearly considering the requirements of class recitation and the issuing of commands to large groups of men.

Section XV. NEUROLOGICAL DISORDERS

5-21. Neurological Disorders

The causes of medical unfitness for USMA are the causes listed in paragraph 2-31.

Section XVI. PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

5-22. Psychoses, Psychoneuroses, and Personality Disorders

The causes of medical unfitness for USMA are the causes listed in paragraphs 2-32, 2-33, and 2-34, plus the following:

a. *Prominent antisocial tendencies, personality defects, neurotic traits, emotional instabil-*

ity, schizoid tendencies, and other disorders of a similar nature.

b. *Stammering or stuttering* which interferes with the candidate's ability to pronounce and enunciate words correctly and clearly, considering the requirements of class recitation and the issuing of commands to large groups of men.

Section XVII. SKIN AND CELLULAR TISSUES

5-23. Skin and Cellular Tissues

The causes of medical unfitness for USMA are the causes listed in paragraph 2-35, plus the following:

a. *Acne*, moderately severe, or interfering

with wearing of military equipment.

b. *Acne scarring.* Severe.

c. *Bromidrosis.* More than mild.

d. *Vitiligo* or other skin disorders which are disfiguring or unsightly.

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

★5-24. Joints, Spine, Scapulae, Ribs, and Sacroiliac

The causes of medical unfitness for USMA are the causes listed in paragraphs 2-11, 2-36, and 2-37, plus the following:

Defects and diseases of the spine, scapulae, ribs, or sacroiliac joints which interfere with the daily participation in a rigorous physical training or athletic program, with the wearing of military equipment, or which detract from a smart military bearing or appearance.

Section XIX. SYSTEMIC DISEASES AND MISCELLANEOUS CONDITIONS AND DEFECTS

5-25. Systemic Diseases and Miscellaneous Conditions and Defects

The causes for rejection for USMA are the same as those listed in paragraphs 2-38 and 2-39, plus the following:

Systemic diseases and miscellaneous medi-

cal conditions and physical defects which interfere with the daily participation in a rigorous physical training or athletic program, with the wearing of military equipment, or which detract from a smart military bearing or appearance.

- 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 the residual obstruction or hydronephroses must be evaluated on an in-

dividual 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 paragraphs 6-28 and 6-29.

6-18. Neck

(See also par. 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

6-22. Height

The causes for rejection are—

Height less than 60 inches or more than 78 inches.

6-23. Weight

The causes for rejection are—

a. Weight related to height which is below the minimum shown in table I, appendix III.

b. Weight related to height and age which is in excess of the maximum shown in table I, appendix III.

6-24. Body Build

The causes for rejection are—

a. Congenital malformation of bones and joints. See paragraphs 6-10, 6-11, and 6-12.

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

c. Evidences of congenital asthenia (slender bones; weak thorax; visceroptosis; severe chronic constipation; or "drop heart" if marked in degree).

d. Obesity. Even though the individual's weight is within the maximum shown in table I, appendix III, he will be reported as medically unacceptable when the medical examiner considers that the individual's weight in relation to the bony structure and the musculature, constitutes obesity of such a degree as would interfere with the satisfactory completion of mandatory training (par. 8, app. I).

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 U.S. 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, 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.

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 trait or sickle cell disease.

c. *Dental.* Paragraph 2-5.d. *Ears and hearing.*

- (1) Paragraphs 2-6 and 2-7.
- (2) Radical mastoidectomy.
- (3) Any infectious process of the ear until completely healed.
- (4) Marked retraction of the tympanic membrane if mobility is limited or if associated with occlusion of the eustachian tube.
- (5) Recurrent or persistent tinnitus.
- (6) History of attacks of vertigo, with or

without nausea, vomiting, 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 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) 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.

★(3) *Color vision.* Failure to identify red and/or green as projected by the Ophthalmological Projector (Federal Stock No. 6515-388-3600) or Armed Forces Vision Tester (Federal Stock No. 6515-299-8084) equipped with Bausch and Lomb Orthorater, Slide No. 71-21-21. (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 if discovered and the incident of spontaneous pneumothorax has not occurred within the preceding 3 months.

o. Mouth, nose, pharynx, larynx, trachea, and esophagus. Paragraphs 2-27, 2-28, 2-29, and 2-30.

p. Neurological disorders.

- (1) Paragraph 2-31.
- (2) Active disease of the nervous system of any type.
- (3) Craniocerebral injury (para 4-23a(7)).

q. Psychoses, psychoneuroses, and personality disorders.

- (1) Paragraphs 2-32, 2-33, and 2-34.
- (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 2-35.

s. Spine, scapulae, and sacroiliac joints.

- (1) Paragraphs 2-36, 2-37, and *e* above.
- (2) Scoliosis: lateral deviation of tips of vertebral spinous processes more than one 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 diseases and miscellaneous conditions and defects.

- (1) Paragraphs 2-38 and 2-39.
- (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. Paragraphs 2-40 and 2-41.

v. Venereal 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.

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

★7-9. 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 *d* below.

★*c.* Rescinded.

d. MAAG's, military attachés, military missions and duty in isolated areas (see AR 55-46, AR 600-200, and AR 612-35).

(1) The following medical conditions and defects will preclude assignment or attachment to duty with MAAG's, military attachés, military missions, or any type duty in isolated oversea stations requiring residence in areas where U.S. military treatment facilities are limited or non-existent:

- (*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 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 from CONUS.
- (4) Findings and recommendations of the examining physicians and dentists will be based entirely on the examination and a review of the Health Record, outpatient, or inpatient medical records. Motivation of the examinee

must be minimized and recommendations based only on the professional judgment of the examiners.

e. The medical fitness standards set forth in *d* above are prescribed for the purpose of meeting selection criteria for military personnel

under consideration for assignment or attachment to duty with MAAG's, 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 U.S. MILITARY ACADEMY

7-10. Medical Fitness Standards for Admission to U.S. 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, U.S. Navy as well as NAVPERS 15,010 Regulations Governing the Ad-

mission of Candidates into the United States Naval Academy as Midshipmen.

7-11. Medical Fitness Standards for Admission to U.S. 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.

Section VIII. SPECIAL ADMINISTRATIVE CRITERIA APPLICABLE TO CERTAIN MEDICAL FITNESS REQUIREMENTS

The special administrative criteria in paragraphs 7-12 through 7-15 are listed for the information and guidance of all concerned.

7-12. Dental—Induction and Appointment or Enlistment in U.S. Army

(See para 2-5.)

The following applies to all individuals undergoing medical examination pursuant to the Universal Military Training and Service Act, as amended, except Medical and Dental Registrants, and to all men and women considered for appointment or enlistment in the U.S. Army, regardless of component, as well as for enrollment in the Advanced Course Army ROTC:

Individuals with orthodontic appliances attached to the teeth are administratively unacceptable so long as active treatment is required. Individuals with retainer orthodontic appliances who are not considered to require active treatment are administratively acceptable.

7-13. Height—Regular Army Commission (See para 2-21a(1).)

The following applies to all males being considered for a Regular Army commission:

a. Individuals being considered for appointment in the Regular Army in other than Armor, Artillery, or Infantry who are not more than 2 inches below the minimum height requirement of 66 inches *will automatically* be considered on an individual basis for an administrative waiver by Headquarters, Department of the Army during the processing of their applications.

b. Individuals being considered for appointment in the Regular Army in Armor, Artillery, or Infantry who are not more than 2 inches below the minimum height requirement of 66 inches *will automatically* be considered for an administrative

waiver by Headquarters, Department of the Army during the processing of their applications provided they have outstanding abilities, military records, or educational qualifications.

7-14. Height—United States Military Academy

(See para. 5-16.)

The following applies to all male candidates to the United States Military Academy:

Candidates for admission to the United States Military Academy who are over the maximum height requirement of 78 inches or up to 2 inches below the minimum height requirement of 66 inches *will automatically* be considered for an administrative waiver by Headquarters, Department of the Army during the processing of their cases, provided they have exceptional educational qualification, have an outstanding military record, or have demonstrated outstanding abilities.

★7-15. **Vision—Officer Assignment to Armor, Artillery, Infantry, Corps of Engineers, Signal Corps, and Military Police Corps (para 2-12 and 2-13)**

Individuals being considered for officer assignment to Armor, Artillery, Infantry, Corps of Engineers, Signal Corps and Military Police Corps must meet the following standards: Uncorrected distant visual acuity of any degree that corrects to at least 20/20 in one eye and 20/100 in the other eye within 8 diopters of plus or minus refractive error.

7-16. **Weight—Enlistment in WAC for Student Nurse Program and Student Dietician Program and Appointment Therefrom**

Medical Fitness Standards for Initial Selection

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)

7-17. **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 7-9c and *d.*

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.

as Members of the Women's Army Corps for Training under the Army Student Nurse and the Army Student Dietician Programs; and the Commissioning from these Programs.

The medical fitness standards for initial selection as members of the Women's Army Corps for Training under the Army Student Nurse and the Army Student Dietician Programs, and for commissioning from these programs are set forth in chapter 2 except that the maximum weight standards set forth in table II, appendix III may be exceeded by 10 percent.

(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 (for individuals of susceptible groups).

(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.

CHAPTER 8

MEDICAL FITNESS STANDARDS FOR MEDICAL AND DENTAL REGISTRANTS UNDER THE UNIVERSAL MILITARY TRAINING AND SERVICE ACT AS AMENDED (Short Title: MEDICO-DENTAL REGISTRANTS MEDICAL FITNESS STANDARDS)

Section I. GENERAL

8-1. Scope

This chapter sets forth the minimum level of medical fitness standards for doctors of medicine and dentistry who are subject to induction or active duty with or without individual consent under the provisions of Section 4, Universal Military Training and Service Act, as amended. (50 USC App 454.)

8-2. Applicability

a. These standards apply only in evaluating a doctor of medicine or dentistry for—

- (1) Induction.
- (2) Appointment in the Medical or Dental Corps in other than the regular component of the Armed Forces.
- (3) Entry on active duty or active duty for training as a Medical or Dental Corps officer of other than the regular component or enlisted reservist of the Armed Forces.

b. These standards are not applicable to an individual who is over 35 years of age or who is otherwise exempt from training and service under the Universal Military Training and Service Act, as amended, or to any individual in determining his eligibility for any corps, except the Medical

and Dental Corps, or for appointment as a regular officer in any corps.

8-3. Department of Defense Policy

The policy of the Department of Defense regarding the medical fitness criteria for physicians and dentists, provides that—

a. All physicians and dentists are considered to be potentially acceptable for military service provided they can reasonably be expected to be productive in the Armed Forces.

b. In general, physicians and dentists with static impairment and those with chronic progressive or recurrent diseases, if asymptomatic or relatively so are considered acceptable for service.

8-4. Questionable Cases

Questionable cases involving the diagnoses listed below will be referred in accordance with current procedures to The Surgeon General, ATTN: MEDPS-SP, Department of the Army, for an opinion of acceptability prior to qualification.

a. *Congenital abnormalities* of heart and great vessels.

b. *Hernia* (only those cases considered irremediable).

c. *Peptic ulcer.*

d. *Psychoneuroses and psychoses.*

e. *Tuberculosis.*

Section II. MEDICAL FITNESS STANDARDS

8-5. Basic Medical Fitness Standards

a. The nature of the duties expected of physicians and dentists is such, in general, that although they may have physical defects or medical

conditions which would ordinarily be cause for rejection for original entry into the military service, they may be expected to perform appropriate military duties as physicians and dentists.

b. The causes of medical unfitness for the purpose shown in paragraph 8-2 are the causes for rejection listed in chapter 3, plus all of the causes listed in this chapter.

8-6. Abdomen and Gastrointestinal System

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-5 and 3-6, chapter 3.

b. *Amebiasis*. A history of amebiasis when active hepatic involvement is present.

c. *Anal fistula* with extensive multiple sinus tracts.

d. *Chronic cholecystitis or cholelithiasis* if disabling for civilian practice.

e. *Liver disease*: A history of liver disease when presence of liver disease is manifested by hepatomegaly or abnormal liver function studies. If disease is considered temporary: Deferment for reexamination at a later date.

f. *Peptic ulcer*: A history of peptic ulcer complicated by obstruction, verified history of perforation, or recurrent hemorrhage is disqualifying. An individual with X-ray evidence of an active ulcer will be deferred for reexamination at a later date. A history of peptic ulcer or a healed ulcer, with scarring but without a niche or crater as demonstrated by X-ray, is acceptable.

g. *Splenectomy*: A history of splenectomy except when the surgery was for trauma, surgery unrelated to disease of the spleen, hereditary spherocytosis, or disease involving the spleen where splenectomy was followed by correction of the condition for a period of at least 2 years.

8-7. Blood and Blood-Forming Tissue Diseases

The causes of medical unfitness for Medical and Dental Registrants are the causes listed in paragraph 3-7, chapter 3.

★8-8. Dental

Dental standards for Medical and Dental Registrants are the same as those listed in paragraph 2-5.

8-9. Ears and Hearing

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraph 3-9, chapter 3.

b. *Auditory acuity*: Hearing which cannot be improved in one ear with a hearing aid to an average hearing level of 20 decibels or less in the speech reception range. Unilateral deafness is not disqualifying.

c. *Meniere's syndrome*: An individual who suffers Meniere's syndrome is disqualified when he has severe recurring attacks which cannot be controlled by treatment or requires hospitalization of sufficient frequency to interfere materially with civilian practice.

d. *Otitis media*, if chronic, suppurative, resistant to treatment, and necessitating hospitalization of sufficient frequency to interfere materially with civilian practice.

8-10. Endocrine and Metabolic Diseases

The causes of medical unfitness for Medical and Dental Registrants are the causes listed in paragraph 3-11, chapter 3.

8-11. Extremities

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-12, 3-13, 3-14, chapter 3 and paragraph 8-23.

b. *Amputation of leg or thigh* if suitable prosthesis is not available or if the use of a cane or crutch is required.

c. *Ankylosis of weight bearing joints*: If the joint is unstable, there is evidence of active or progressive disease, or if fusion interferes with physical activities to such an extent that use of a cane or crutch is required.

d. *Congenital or acquired deformities* of the feet when shoes cannot be worn or if the individual is required to use a cane or crutches.

e. *Dislocated semilunar cartilage* when disabling for civilian practice.

f. *Loss of fingers or toes*: Qualification will be based upon the individual's ability to perform civilian practice in his specialty.

g. *Osteomyelitis*: Healed osteomyelitis when there has been X-ray or other evidence of bone infection within the preceding 12 months. Drainage or disturbance of weight-bearing function during the previous year makes the individual medically unfit.

h. Paralysis secondary to poliomyelitis when suitable brace cannot be worn or if cane or crutches are required for the lower extremities. Mobility of the extremities should be adequate to assure useful function thereof and a military appearance.

i. Old ununited or malunited fractures, involving weight-bearing bones when there is sufficient shortening or deformity to prevent the performance of military duty.

8-12. Eyes and Vision

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-15 and 3-16.

b. Absence of an eye when there is active disease in the other eye or the vision in the remaining eye is less than the standards in *c* below.

c. Visual Acuity. Any degree of uncorrected vision which will not correct to at least 20/30 in the better eye or when the defective vision is due to active or progressive organic disease.

8-13. Genitourinary System

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-17 and 3-18.

b. Chronic prostatitis or hypertrophy of prostate, with evidence of urinary retention.

c. Kidney.

(1) Absence of one kidney where there is progressive disease or impairment of function in the remaining kidney.

(2) Cystic (polycystic kidney). Asymptomatic, history of.

d. Nephritis. A history of nephritis, with residuals such as hypertension or abnormal urinary or blood findings.

e. Nephrolithiasis. A history of nephrolithiasis with evidence of the presence of a stone at the time of examination.

8-14. Head and Neck

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-19 and 3-20.

b. Skull defects are acceptable unless resid-

ual signs and symptoms are incapacitating in civilian practice.

8-15. Heart and Vascular System

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-21, 3-22, and 3-23.

b. Auricular fibrillation: Paroxysmal auricular fibrillation with evidence of organic heart disease, or persistent auricular fibrillation from any cause.

c. Auriculoventricular block, when due to organic heart disease.

d. Coarctation of the aorta and other significant congenital anomalies of the vascular system unless satisfactorily treated by surgical correction.

e. Hypertension. Blood pressure frequently elevated to 200/120 or more (which returns to normal limits with rest and sedatives) or a persistent diastolic pressure over 110-mm mercury even though cerebral, renal, cardiac, and retinal findings are normal.

f. Phlebitis. Recurrent phlebitis, other than mild. Residuals of phlebitis, such as persistent edema, dermatitis, ulceration, or claudication, which interfere materially with civilian practice, also make the individual medically unfit.

g. Valvular heart disease. Cardiac insufficiency at a functional capacity level of Class IIC or worse, American Heart Association (app VII).

h. Varicose veins associated with ulceration of the skin, symptomatic edema, or recurring incapacitating dermatitis.

★*i. Rheumatic fever.*

(1) Residuals involving the heart at a functional capacity level of Class IIC or worse, American Heart Association (app VII).

(2) Verified history of recurrent attacks, cardiac involvement, or subacute bacterial endocarditis within the past 2 years.

8-16. Height, Weight, and Body Build

The causes for medical unfitness for Medical and Dental Registrants are the causes listed in paragraphs 3-24, 3-25, and 3-26.

8-17. Lungs and Chest Wall

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-27, 3-28, and 3-29.

★*b. Bronchial asthma.* Associated with emphysema of sufficient degree to interfere with performance of duty, or with frequent attacks controlled only by continuous systemic corticosteroid therapy, or with frequent attacks which are not controlled by oral medication.

c. *Bronchiectasis and emphysema.* When outpatient treatment or hospitalization is of such frequency as to interfere materially with civilian practice. Bronchiectasis confined to one lobe is usually acceptable; however, the saccular, systic, and dry types, involving more than one lobe, make the individual medically unfit.

d. *Chronic bronchitis* complicated by disabling emphysema or requiring outpatient treatment or hospitalization of such frequency as to interfere materially with civilian practice.

e. *Pleurisy with effusion.* An individual with serofibrinous pleurisy due to known or proven acute or inflammatory conditions may be considered as acceptable for military service if there has been no recurrence for 1 year. If the effusion exceeds 100 cc, is not transient in character, and does not appear to be secondary to pneumonia or other demonstrable non-tuberculous disease, it will be considered to be a manifestation of active tuberculosis and will be disqualifying until the disease has become inactive and remained so for 5 years.

f. *Sarcoidosis.* Symptomatic pulmonary sarcoidosis which has not responded promptly to therapy or which is complicated by residual pulmonary fibrosis.

g. *Spontaneous pneumothorax* with recovery is acceptable.

h. *Tuberculosis.* Uncomplicated minimal tuberculosis which has been adequately treated is acceptable provided serial X-rays indicate that the lesion has remained stable for 2 years of full physical activity. An arbitrary time limit cannot definitely be established when an individual who has had tuberculosis can safely be accepted for military service. The 2 years specified may not always be applicable. The borderline between minimal and moderately ad-

vanced tuberculosis is not always definite since a lesion may be classified as either minimal or moderately advanced by several different competent observers. The difference between moderately advanced and far advanced tuberculosis disease is less controversial. If an individual has a history of minimal tuberculosis and X-rays reveal a lesion which is well calcified and which has appeared stable for 2 years of full physical activity, he can with reasonable certainty be expected to perform useful military service. If an individual is on restricted activity or under treatment or has a moderately advanced or far advanced lesion, then he will be considered disqualified for military service for at least 2 years. Moderately advanced lesions which have healed satisfactorily and have remained arrested for as long as 5 years with the individual allowed full activity are acceptable. An individual with a verified history of tuberculosis pleurisy with effusion which has not been clinically active or caused restricted activity within the previous 5 years is acceptable.

8-18. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraph 3-30.

b. *Polyps or mucocoeles*, when moderate to severe, suppurative, and unresponsive to treatment.

c. *Chronic sinusities*, when moderate to severe, suppurative, and unresponsive to treatment.

8-19. Neurological Disorders

The causes of medical unfitness for Medical and Dental Registrants are the causes listed in paragraph 3-31.

8-20. Psychoses, Psychoneuroses, and Personality Disorders

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-32, 3-33, 3-34, and 3-35.

b. *Psychoneurosis* when severe and incapacitating for practice in civilian life. An individual who is undergoing continuous active neuropsychiatric therapy should be deferred and reconsidered at a later date. Neuropsychiatric

consultation, in addition to Standard Forms 88 and 89 on an individual who is or claims to be a sexual deviate will be referred to The Surgeon General, ATTN: MEDPS-SP, Department of the Army, for an opinion of acceptability prior to qualification.

c. Psychosis of organic or functional etiology except if in complete remission for 2 years or more. Neuropsychiatric consultation, in addition to Standard Forms 88 and 89, will be sent to The Surgeon General, ATTN: MEDPS-SP, Department of the Army, Washington, D.C., 20315, for an opinion of acceptability prior to qualification.

8-21. Skin and Cellular Tissues

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraph 3-36.

b. Chronic dermatitis more than mild in degree, generalized, requiring frequent outpatient treatment or hospitalization or if it has been resistant to prolonged periods of treatment.

c. Pilonidal cysts are acceptable.

8-22. Spine, Scapulae, Ribs and Sacroiliac Joints

Causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraph 3-37.

b. Intervertebral disc syndrome when there are definite objective abnormal findings on physical examination.

c. Osteoarthritis. When there is persistent pain and limited function associated with objective X-ray evidence and documented history of recurrent incapacity for prolonged periods.

d. Scoliosis when the deformity is so marked as to be apparent and objectionable when wearing the uniform.

★*e. Spondylolysis, spondylolisthesis* or other congenital anomalies of the spine with significant recurrent symptoms on moderate or normal activity.

8-23. Systemic Diseases and Miscellaneous Conditions and Defects

The causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-38 and 3-39.

b. Tuberculosis.

(1) Pulmonary tuberculosis. See paragraph 8-17*h*.

(2) Active tuberculosis of a bone or joint or a verified history of tuberculosis of a bone or joint.

c. Sarcoidosis. See also paragraph 8-17*f*.

8-24. Tumors and Malignant Diseases

Causes of medical unfitness for Medical and Dental Registrants are—

a. Paragraphs 3-40, 3-41, and 3-42.

b. Malignant growths are generally disqualifying. Those which have been entirely removed without evidence of metastasis, which are of a type from which a "cure" may be expected after removal, and which have had adequate follow-ups are acceptable.

8-25. Venereal Diseases

The causes of medical unfitness for Medical and Dental Registrants are the causes listed in paragraph 3-43.

★CHAPTER 9 PHYSICAL PROFILING

Section I. GENERAL

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 preinduction medical examination pursuant to the Universal Military Training and Service Act (50 USC, Supplement IV, appendix 454, as amended).

b. Applicants for enlistment or appointment in the United States Army.

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 Armed Forces examining 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 functional ability of an individual to perform military duties. In relation to this performance, 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 his 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. In developing the system, the human functions have been considered under six factors. For ease in accomplishing and applying the profile system, 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 *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 or stamina and reflects organic defects or diseases which affect general physical capacity and which do not fall under other factors of this system. 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 organs; 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 functional use of 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 functional use of 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 (physical and mental) fitness and, consequently, he is medically fit for any military assignment.
- (2) A physical profile "2" under any or all factors indicates that an individual meets procurement (entry) standards, but possesses some medical condition or physical defect which precludes initial assignment to Ranger training, Airborne, or Special Forces. His assignment is not otherwise limited. However, there may be limitations on initial MOS classification. See AR 611-203.
- (3) A profile containing one or more numerical designation "3" signifies that the individual has medical condition(s) or physical defect(s) which requires certain restrictions in assignment within which he is physically capable of performing full military duty. Such individuals are not acceptable under procurement (entry) standards in time of peace, but may be acceptable in time of partial or total mobilization. They meet the retention standards, while in service, but should receive assignments commensurate with their functional capability.
- (4) A profile serial containing one or more numerical designation "4", indicates that the individual has a medical condition or physical defect which is below the level of medical fitness for retention (continu-

ance) in the military service during peacetime. See Code designations "V" and "W" (par. 9-5).

d. Anatomical defects or pathological conditions will not of themselves form the sole basis of classification. Since minor physical defects or medical conditions have different values in relation to performance of duties they will not automatically necessitate assignment limitations. While these defects must be given consideration in accomplishing the profile, it is important to consider function and prognosis, especially regarding the possibility of aggravation. In this connection, a close relationship must exist between medical officers and personnel management officers. The determination of assignment is an administrative procedure. The medical officer's report assists the personnel management officer in assessing the individual's medical capability to fill duty positions. It is, therefore, the responsibility of the personnel management officer, based on his knowledge of the individual's profile, to determine whether the individual may be employed in certain duty positions. Appendix VIII contains a Physical Profile Functional Capacity Guide.

9-4. Modifier to Serial

To make the profile serial more informative, the modifier "R" or "I" 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. *"R"—Remediable.* This modifier indicates that the condition necessitating numerical designation "3" or "4" is considered remediable, the correction or treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. An individual on active duty with an "R" 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 an "R" modifier for more than 12 months without positive action being taken either to correct the defect or to effect other appropriate disposition. As a general rule the medical officer initiating the "R" modifier will initiate appropriate arrangements for the necessary correction or treatment of the remediable condition.