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 persisent 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 a major joint of any degree including operation therefor.

(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.

(2) Distant visual acuity.

(*a*) Airborne training. Paragraph 3-16.

(*b*) Ranger training. Paragraph 2-13.

(*c*) Special forces training. Uncorrected less than 20/200 in each eye or not correctable to 20/20 in each eye.

★(3) *Color vision:* (No requirement for Ranger Training).

(*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).

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) Persistant 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 (par. 4-23*a* (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 *c* and *d* below.

c. Fort Churchill, Canada.

(1) The following preclude assignment to Fort Churchill, Canada:

(*a*) Anomalies of the cardiovascular system or plasma or other conditions which are adversely affected by extreme cold or may result in frostbite.

(*b*) Artificial limbs, braces, or artificial eye.

(*c*) Chronic, symptomatic sinusitis, more than mild.

(*d*) History of prolonged or repeated treatment for a nervous, emotional, or mental disorder.

(*e*) History or residuals of cold injury cases will be evaluated as outlined in TB MED 81.

(*f*) Skin hypersensitive to sun or wind.

(2) Any dental, medical, or physical condition or defect which might reasonably be expected to require care during a tour at Fort Churchill will be corrected prior to the individual's departure for this assignment.

d. MAAG, military attachés, and military missions.

(1) The following preclude assignment to MAAG, military attachés, or military missions:

(*a*) The current requirement of any maintenance medication of such toxicity as to require frequent clinical and laboratory followups.

(*b*) History of prolonged or repeated treatment for a nervous, emotional, or mental disorder.

(*c*) A history of peptic ulcer.

(*d*) A history of colitis.

(*e*) Inherent, latent, or incipient medical conditions or physical defects which might make the examinee's residence in a given country inadvisable because of the effect(s) of climatic or other factors on the medical condition or physical defect.

(2) Any dental, medical, or physical condition or defect which might reasonably be expected to require care during a tour outside of the continental United States will be corrected prior to the departure of an individual for such a tour of duty.

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 in 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 par. 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 being 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 par. 2-21*a*(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 par. 5-16.)

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

a. Candidates for admission to the U.S. Military Academy under 20 years of age on 1 July of the year of entry who are not more than 1 inch 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 such cases.

b. Candidates for admission to the U.S. 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 qualifications, 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

(See par. 2-13.)

a. Individuals being considered for officer assignment to Armor, Artillery, Infantry, Corps of Engineers, Signal Corps, or Military Police Corps who exceed the criteria listed below are administratively unacceptable for such assignment:

(1) Distant visual acuity: 20/200 in each eye correctable to 20/20 in one eye and 20/40 in the other eye.

(2) Refractive error:
(*a*) Hyperopia: 5.00 diopters.
(*b*) Myopia: 3.00 diopters.

b. Individuals who have been designated as Distinguished Military Graduates of the Army ROTC accepting Regular Army commissions or who are graduates of the U.S. Military Academy will automatically be considered for an administrative waiver by Headquarters, Department of the Army during the processing of their cases for assignment to Armor, Artillery, Infantry, Corps of Engineers, Signal Corps, or Military Police Corps, if they meet the following:

(1) Distant visual acuity: Any degree of uncorrected visual acuity which corrects to 20/20 in both eyes.
(2) Refractive error:
(*a*) Hyperopia: 5.50 diopters.
(*b*) Myopia: 5.50 diopters.
(*c*) Astigmatism: 3.00 diopters.
(*d*) Anisometropia: 3.50 diopters.

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

Medical Fitness Standards for Initial Selection as Members of the Women's Army Corp for Training under the Army Student Nurse and the Army Student Dietician Programs; and for 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.

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 of 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) Open marginal or central perforations 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 par. 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.

Section VI. ENDOCRINE AND METABOLIC DISORDERS

2–8. Endocrine and Metabolic Disorders

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

a. Adiposogenital dystrophy (Frohlich's syndrome) more than moderate in degree.

b. Adrenal gland, malfunction of, of any degree.

c. Cretinism.

d. Diabetes insipidus.

e. Diabetes mellitus.

f. Gigantism or acromegaly.

g. Glycosuria, persistent, regardless of cause.

h. 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.

i. Gout.

j. Hyperinsulinism, confirmed, symptomatic.

k. Hyperparathyroidism and *hypoparathyroidism.*

l. Hypopituitarism, severe.

m. Myxedema, spontaneous or postoperative (with clinical manifestations and not based solely on low basal metabolic rate).

n. Nutritional deficiency diseases (including Prue, beriberi, pellagra, and scurvy) which are more than mild and not readily remediable or in which permanent pathological changes have been established.

o. 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 par. 2-11.)

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

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 ⅓ 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 the right or left hand irrespective of the absence (or loss) of the small fingers. Two of three fingers (index, middle, and ring fingers) must be intact.

(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 par. 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.

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) Flat foot, 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) Flat foot, 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 pars. 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 (atrophic 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; in-

stability 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.

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.

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) Dacrocystitis, 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 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 diseases, macular cysts, holes, and other degenerations (hereditary or acquired) affecting the macula 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 Coats' 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 diopters deviation or more.
(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, 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 not correct 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 pars. 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 below.

h. New growths of the internal or external genitalia except single uterine fibroid, subserous, 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 pars. 2-40 and 2-41.)

(1) Absence or non-descent of both testicles.

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

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 pars. 2-8, 2-40, and 2-41.)

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

a. Albuminuria including so-called orthostatic or functional albuminuria, other than that produced by obvious extrarenal disease.

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

c. Enuresis subsequent to the age of 8. See also paragraph 2-34*c*.

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 25 square centimeters 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 tuberculous 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 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: incomplete A-V block, left bundle branch block, right bundle branch block unless cardiac evaluation reveals no cardiac disease and block is presumably congenital.

(3) 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 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 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 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 persistent blood pressure readings of 150-mm or more systolic in an individual over 35 years of age or persistent readings of 140-mm or more systolic in an individual 35 years of age or less. Persistent 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 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, 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 pars. 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, 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 par. 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 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 preceding 5 years.

q. Sarcoidosis.

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 or 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:*
(1) Evidenced by chronic purulent nasal discharge, large nasal polyps, hyperplastic changes of the nasal tissues and other signs and symptoms.
(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 diseases of, such as ulceration, varices; achalasia; peptic esophagitis; if confirmed by appropriate X-ray or esophagoscopic 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 ventricularis.*

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 par. 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.
(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 immature disorders such as authenticated evidence of enuresis not due to organic condition (see also par. 2-15), 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 as listed in SR 40-1025-2.

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.

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.

(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 do not interfere with military duty.

f. For tumors of the internal or external female genitalia see paragraph 2-14*h*.

2-41. Malignant Diseases and Tumors

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

a. Leukemia, acute or chronic.

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 2-12*a*(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 considered evidence of chronic venereal disease which has not responded to treatment (par. 2-39*f*).

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 2-31*c*.

3-23. Miscellaneous

The causes of medical unfitness for further 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 180 mm of mercury or a diastolic pressure of over 110 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 3 (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 inability of the individual to perform duties without discomfort or dyspnea.

Section XII. HEIGHT, WEIGHT, AND BODY BUILD

3-24. Height

Under-height or over-height: Per se, *does not* render the individual medically unfit.

3-25. Weight

Over-weight or under-weight: Per se, *does not* render the individual medically unfit. However, the etiological factor may in itself render the individual medically unfit.

3-26. Body Build

a. Obesity: Per se, *does not* render the individual medically unfit. However, the etiological factor in itself may render the individual medically unfit.

b. Deficient muscular development which is the result of injury or illness does not in itself render the individual medically unfit. However, as a residual or complication of injury or illness it may contribute to overall medical unfitness.

Section XIII. LUNGS AND CHEST WALL

3-27. Tuberculous Lesions

(See also par. 3-28.)

The causes of medical unfitness for further military service are—

a. Pulmonary tuberculosis except as stated below.

(1) Individuals on active duty will be held for definitive treatment when—

(*a*) The disease is service incurred.

(*b*) The individual's return to useful duty can be expected within 12 to 15 months, inclusive of a period of inactivity of 1 to 6 months or more. See TB Med 236.

(2) Members of the Reserve Components, not on active duty will be found fit for retention in this status, not subject to call to active duty for training, inactive duty training, or mobilization for a period not to exceed 12 to 15 months when the individual will be capable of performing full time useful military duty within 12 to 15 months with appropriate treatment, inclusive of a period of inactivity of 6 months or more. See TB Med 236.

b. Tuberculous empyema.

c. Tuberculous pleurisy: Same as pulmonary tuberculosis (*a* above).

3-28. Nontuberculous Lesions

The causes of medical unfitness for further military service are—

a. Asthma: Associated with emphysema of sufficient degree to interfere with performance of

duty or frequent attacks 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: Cylindrical or saccular type which is moderately symptomatic, with or without paroxysmal cough at frequent intervals throughout the day, mild emphysema, recurrent pneumonia, loss in weight, or frequent hospitalization.

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 defect: Symptomatic.

g. Hemopneumothorax, hemothorax and pyopneumothorax: More than moderate pleuritic residuals with persistent underweight, marked restriction 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 to 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: Not responding to therapy or complicated by residual pulmonary insufficiency.

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.

q. Stenosis, trachea.

★ 3-29. Surgery of the Lungs and Chest

The causes of medical unfitness for further 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

3-30. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

The causes of medical unfitness for further 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 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 the individual to have difficulty in maintaining weight and nutrition, when the condition does not respond 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

aa. Tuberculosis of the skin: See paragraph 3-38*g*(5).

ab. Ulcers of the skin: Not responsive to treatment after an appropriate period of time or if interfering with the satisfactory performance of duty.

ac. Urticaria: Chronic, severe, and not amenable to treatment.

ad. Xanthoma: Regardless of type, 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 XVIII. SPINE, SCAPULAE, RIBS, AND SACROILIAC JOINTS

3-37. Spine, Scapulae, Ribs, and Sacroiliac Joints

(See also par. 3-14.)

The causes of medical unfitness for further military service are—

a. Abdominopelvic amputation.

b. Congenital anomalies:

(1) Dislocation, congenital, of hip.

(2) Spina bifida: Associated with pain to the lower extremities, muscular spasm, and limitation of motion which has not been amenable to treatment or improved by assignment restrictions.

(3) Spondylolisthesis or spondylolysis: More than mild displacement and more than mild symptoms on normal activity.

(4) Others: Associated with muscular spasm, pain to the lower extremities, postural deformities, and limitation of motion which have not been amenable to treatment or improved by assignment limitations.

c. Coxa vara: More than moderate with pain, deformity, and arthritic changes.

d. Disarticulation of hip joint.

e. Herniation of nucleus pulposus: More than mild symptoms with sufficient objective findings, following appropriate treatment or remediable measures, of such a degree as to interfere with the satisfactory performance of duty.

f. Kyphosis: More than moderate, interfering with function, or causing unmilitary appearance.

g. 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

3-38. Systemic Diseases

The causes of medical unfitness for further military service are—

a. Blastomycosis.

b. Brucellosis: Chronic 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: Symptomatic and not responding to therapy or complicated by residual pulmonary fibrosis.

g. Tuberculosis:

(1) Meningitis, tuberculous.

(2) Pulmonary tuberculosis, tuberculous empyema, and tuberculous pleurisy. See paragraph 3-27.

(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.

3-39. General and Miscellaneous Conditions and Defects

The causes of medical unfitness for further military service are—

a. Allergic manifestations:

(1) Allergic rhinitis. See paragraph 3-30*d* and *e*.

(2) Asthma. See paragraph 3-28*a*.

(3) Allergic dermatoses. See paragraph 3-36.

(4) Visceral, abdominal, or cerebral allergy: Severe, or not responsive to therapy.

b. Cold injury residuals (frostbite, chilblain, immersion foot, or trench foot): With chronic objective and subjective findings, listed in TB Med 81 (cold injury) or loss of parts as outlined in paragraphs 3-12 and 3-13.

c. Miscellaneous medical conditions and physical defects, not elsewhere provided for in this chapter, which—

(1) Obviously precludes the individual's satisfactory performance of duty.

(2) Would compromise the individual's health and well-being if he were to remain in the military service.

(3) Would prejudice the interests of the Government if the individual were to remain in the military service.

Questionable cases not falling within the above may be referred to The Surgeon General for an opinion of medical fitness prior to Physical Evaluation Board processing.

Section XX. TUMORS AND MALIGNANT DISEASES

3-40. Malignant Neoplasms

The causes of medical unfitness for further military service are—

Malignant growths when inoperable, metasta sized beyond regional nodes, recur subsequent to treatment, or the residuals of the remedial treatment are in themselves incapacitating. The complete removal of malignant growths without evidence of metastasis *does not* render the individual medically unfit.

a. Individuals on active duty who refuse treatment will be considered as medically unfit only if their condition precludes their satisfactory performance of duty.

b. Individuals on active duty whose followup period has been deemed inadequate at the time of medical evaluation prior to separation or retirement, should, if indicated, be processed as provided in paragraph 3-4*a* with a view to placement on the Temporary Disability Retired List for an additional followup period.

c. Individuals not on active duty who refuse treatment will be considered as medically unfit.

3-41. Neoplastic Conditions 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 further military duty. Individuals on active duty who are relatively asymptomatic, who are of special value to the service, and who can be assigned where adequate medical followup facilities are available, may be recommended for continuance on active duty.

3-42. Benign Neoplasms

a. Benign tumors, except as noted below, are not generally cause for medical unfitness because they are usually remediable. Individuals who refuse treatment will be considered medically unfit only if their condition precludes their satisfactory performance of a military job.

b. The following, upon the diagnosis thereof, are considered to render the individual unfit for further military service.

(1) *Ganglioneuroma.*

(2) *Meningeal fibroblastoma*, when the brain is involved.

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 uveal tract; acute, chronic or recurrent.

f. Pterygium which encroaches on the cornea more than 1mm 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 Vision Test Set, Color Vision, 15 Plates.

(*b*) Four or more errors in reading the 17 Test Plates of the A.O.C. Abridged Pseudoisochromatic Plates when used in lieu of (*a*) above.

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

(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.

(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 diopters.

(*b*) Hyperopia in excess of 1.75 diopters in any meridian.

(*c*) Myopia in excess of 0.25 diopters 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 diopters.

(b) Hyperopia:

1. Individuals under age 35: Greater than 1.75 diopters in any meridian.

2. Individuals age 35 or over: Greater than 2.00 diopters in any meridian.

(c) Myopia greater than 0.75 diopters in any meridian.

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

(1) *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) Flight-Simulator Specialists: Distant visual acuity which is not correctable to 20/20 in each eye.

(c) Pilots: Uncorrected less than 20/100 in each eye or not correctable to 20/20 in each eye.

(2) *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.

(3) *Near visual acuity.* Uncorrected less than 20/100 (J-16) in each eye or not correctable to 20/20 in each eye.

(4) *Ocular motility:* Hyperphoria greater than 1.5 prism diopters.

(5) *Refractive Error:* No maximum limits prescribed.

d. Class 3:

(1) *Color vision:* Same as Class 1, paragraph 4-12a(5).

(2) *Distant visual acuity:* Uncorrected less than 20/200 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.

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, 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 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 of 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 medication.

(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 crainiotomy 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 other 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, 2-35, and 4-27*d* 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.

★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 a major joint of any degree including operation therefor.

(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.

(2) Distant visual acuity.

(*a*) Airborne training. Paragraph 3-16.

(*b*) Ranger training. Paragraph 2-13.

(*c*) Special forces training. Uncorrected less than 20/200 in each eye or not correctable to 20/20 in each eye.

(3) Color vision—four or more errors in reading the 17 test plates of the AOC Abridged Pseudoisochromatic Plates.

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 (par. 4-23*a*(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.

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—five or more errors in reading the 14 test plates of the Vision Test Set, color vision, 15 plates, or 4 or more errors in reading the 17 test plates of the A.O.C. Abridged Pseudoisochromatic Plates.
(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 4-16*h*.

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.

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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 gastrointestional 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 Specialities

a. The medical fitness standards to be utilized in the *initial selection* of individuals to enter a specific enlisted military occupational speciality (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

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

The causes of medical unfitness for Medical and Dental Registrants are the causes listed in paragraph 3–8, chapter 3.

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.

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s/s c 6 16 Mar 1962

(2) Degenerations of the retina to include macular diseases, macular cysts, holes, and other degenerations (hereditary or acquired) affecting the macula 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 Coats' 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 diopters deviation or more.
(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, 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 not correct 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 pars. 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 below.

h. New growths of the internal or external genitalia except single uterine fibroid, subserous, asymptomatic, less than 3 centimeters in diameter, with no general enlargment 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 pars. 2–40 and 2–41.)

(1) Absence or non-descent of both testicles.

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

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 pars. 2–8, 2–40, and 2–41.)

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

a. Albuminuria including so-called orthostatic or functional albuminuria, other than that produced by obvious extrarenal disease.

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

c. Enuresis subsequent to the age of 8. See also paragraph 2–34*c*.

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) Hydronephrosis or pyonephrosis.

(4) Nephritis, acute or chronic.
(5) Pyelitis, pyelonephritis.

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

i. Peyronie's disease.

j. Prostrate 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 25 square centimeters 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 tuberculous 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.

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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: incomplete A-V block, left bundle branch block, right bundle branch block unless cardiac evaluation reveals no cardiac disease and block is presumably congenital.

(3) 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 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 pericarditis or coxsackie with no residuals.

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 interfers 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 persistent blood pressure readings of 150-mm or more systolic in an individual over 35 years of age or persistent readings of 140-mm or more systolic in an individual 35 years of age or less. Persistent 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;

c. Nasal septum, performation of:
(1) Associated with interference of function, ulceration or crusting, and when the result of organic disease.
(2) If progressive.
(3) If respiration is accompanied by a whistling sound.

d. Sinusitis, acute.

e. Sinusitis, chronic:
(1) Evidenced by chronic purulent nasal discharge, large nasal polyps, hyperplastic changes of the nasal tissues and other signs and symptoms.
(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 diseases of, such as ulceration, varices; achalasia; peptic esophagitis; if confirmed by appropriate X-ray or esophagoscopic 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 ventricularis.

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 par. 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.
(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 immature disorders such as authenticated evidence of enuresis not due to organic condition (see also par. 2-15), 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 as listed in SR 40-1025-2.

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: Of such a size or location as to interfere with the normal wearing of military equipment.

d. Dermatitis factitia.

e. Dermatitis herpetiformis.

f. Eczema: Any type which is chronic and resistant to treatment.

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; Hodgkin's disease.

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 medical conditions and physical defects which, upon detection, make an individual medically unfit for further military service. This includes medical examinations accomplished at any time such as—

a. Periodic.

b. Promotion.

c. Active duty, active duty for training, inactive duty training, and mobilization of units and members of the Reserve components of the Army.

d. Reenlistment within 90 days of separation.

e. Separation including retirement.

3-2. Applicability

a. These standards apply to the following regardless of grade, branch of service, MOS, age, length of service, component, or service connection:

(1) All personnel on active duty including active duty for training.

(2) All members of the Army National Guard of the United States, not on active duty.

(3) All members of the Army Reserve, not on active duty, except members of the Retired Reserve.

(4) Personnel approved for continuance (waiver) under AR 616-41, AR 140-120, and NGR 27, except for medical conditions and physical defects for which continuance has been approved. These standards will apply upon termination (or withdrawal) of continuance under AR 616-41, AR 140-120, or NGR 27.

b. These standards *do not apply* in the determination of an individual's medical fitness for Army Aviation, Airborne, Marine Diving, Ranger, or other assignments or duties having different medical fitness standards for retention therein.

3-3. Evaluation of Physical Disabilities

a. An individual will not be declared medically unfit for further military service (par. 3-1) under these standards because of disabilities which were known at the time of initial acceptance for military service or continuance under AR 616-41, AR 140-120, or NGR 27 when the medical condition or physical defect is essentially unchanged and has not interfered with the individual's successful performance of duty.

b. These standards take into consideration the individual's medical fitness to perform satisfactory military duty; the nature, degree, and prognosis of the condition or defect; and the effect of continued service in the military environment upon the health of the individual. Most members possess some physical imperfections which, although rateable in the Veterans Administration Schedule for rating disabilities, do not, per se, preclude the individual's satisfactory performance of military duties. The presence of physical imperfections whether or not they are rateable, should routinely be made a matter of record whenever discovered.

c. Lack of motivation for service should not influence the medical examiner in evaluating disabilities under these standards. Poorly motivated individuals who are medically fit for duty will be recommended for administrative disposition.

3-4. Disposition of Personnel Who Are Medically Unfit Under These Standards

★ *a.* Individuals on active duty including active duty for training who are medically unfit under these standards will be processed for disability separation (including retirement) in accordance with the procedures contained in AR 40-212, AR 635-40A, and AR 635-40B for the purpose of determining their eligibility for physical disability benefits under title 10, United States Code, chapter 61 (formerly title IV, Career Compensation

Act of 1949) or for continuance on active duty with deferment of disability separation (waiver) as outlined in AR 616-41. When the standards prescribed for either partial or total mobilization in chapter 6 are in effect, or as directed by the Secretary of the Army, individuals who are medically unfit under these standards but who are medically fit under the total mobilization medical fitness standards in chapter 6 will be continued on active duty and their disability separation processing deferred for the duration of the mobilization or as directed by the Secretary of the Army; those who are medically unfit under total mobilization medical fitness standards will be processed for disability separation.

b. Individuals *not on active duty* who are medically unfit under these standards will be administratively processed in accordance with AR 140-120, NGR 25-3, or NGR 62, as appropriate, for disability separation or continuance in Reserve component status (waiver) as prescribed therein. Individuals who become medically unfit under these standards by reason of injury incurred during a period of inactive duty training will be processed as prescribed in AR 40-212.

c. Active duty personnel who are *administratively unfit* for retention will be processed in accordance with the procedures contained in appropriate administrative regulations such as AR 635-89, AR 635-105, AR 635-206, AR 635-208, and AR 635-209.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

3-5. Abdominal and Gastrointestinal Defects and Diseases

The causes for medical unfitness for further military service are—

a. Achalasia (Cardiospasm): Dysphagia not controlled by dilatation, with continuous discomfort, or inability to maintain weight.

b. Amebic abscess residuals: Persistent abnormal liver function tests after appropriate treatment.

c. Biliary dyskinesia: Frequent abdominal pain not relieved by simple medication, or with periodic jaundice.

d. Cirrhosis of the liver: Recurrent jaundice, ascites, or demonstrable esophageal varices or history of bleeding therefrom; failure to maintain weight and normal vigor.

e. Gastritis: Severe, chronic hypertrophic gastritis with 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: Symptoms not relieved by simple dietary or medical means, or recurrent bleeding in spite of prescribed treatment.

(2) If operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

h. Ileitis, regional: Confirmed diagnosis thereof. However, individuals on active duty who are able to maintain weight, have no significant abdominal pain, have no signs of anemia, average no more than 4 bowel movements per day, have a good understanding of the disease, who do not require frequent medical attention and who are of special value to the service may be recommended for continuance on active duty.

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 with repeated admissions to the hospital.

l. Ulcer, peptic, Duodenal and gastric: Frequent recurrence of symptoms (pain, vomiting, and bleeding) in spite of good medical management and supported by laboratory and X-ray evidence.

m. Ulcerative colitis: Confirmed diagnosis

thereof. However, individuals on active duty who are able to maintain weight, have no significant abdominal pain, have no signs of anemia, average no more than 4 bowel movements per day, have a good understanding of the disease, and who are are of special value to the service may be recommended for continuance on active duty.

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 or surgical treatment.

3-6. Gastrointestinal and Abdominal Surgery

The causes of medical unfitness for further military service are—

a. Colectomy partial, when more than mild symptoms of diarrhea remain or if complicated by colostomy.

b. Colostomy: Per se, when permanent. However, individuals on active duty who have no diarrhea or indigestion and who can be assigned to installations where adequate medical supervision is available may be recommended for continuance on active duty if they are of special value to the service.

c. Enterostomy, if permanent.

d. Gastrectomy: Per se. However, individuals on active duty who have had a partial gastrectomy and are able to exist on a normal diet without symptoms of indigestion or loss of weight may be recommended for continuance on active duty if they are of special value to the service.

e. Gastrostomy, permanent.

f. Gastroduodenostomy: Per se. However, individuals on active duty who have no complications, are without symptoms of indigestion, nausea and vomiting, or weight loss, and who can select their diet from a normal diet may be recommended for continuance on active duty if they are of special value to the service.

g. Ileostomy, permanent.

h. Pancreatectomy.

i. Pancreaticoduodenostomy and Pancreaticogastronomy: More than mild symptoms of digestive disturbance or requiring insulin.

j. Pancreaticojejunostomy: If for cancer in the pancreas or, if more than mild symptoms of digestive disturbance and requiring insulin.

k. Proctectomy.

l. Proctopexy, proctoplasty, proctorrhaphy, and 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

(See also par. 3-41.)

Any of the following make the individuals medically unfit for further military service when the condition is such as to preclude satisfactory performance of military duty, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged intensive medical supervision.

a. Anemia.

b. Hemolytic crisis, chronic and symptomatic.

c. Leukopenia, chronic and not responsive to therapy.

d. Polycythemia.

e. Purpura and other bleeding diseases.

f. Thromboembolic disease.

g. Splenomegaly, chronic and not responsive to therapy.

Section IV. DENTAL

3-8. Dental Diseases and Abnormalities

Diseases or abnormalities of the jaws or associated tissues render an individual medically unfit when permanently incapacitating or interfering with the individual's satisfactory performance of military duty.

Section V. EARS AND HEARING

3-9. Ears

The causes of medical unfitness for further military service are—

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 or hospitalization.

b. Malfunction of the acoustic nerve: Over 30 decibels hearing level (by audiometer) in the better ear, severe tinnitus which cannot be satisfactorily corrected 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. Méniere's syndrome: Severe recurring attacks requiring hospitalization of sufficient frequency to interfere with the performance of military duty, or when the condition is not controlled by any treatment.

e. Otitis Media: Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent hospitalization.

f. Perforation of the tympanic membrane, per se, is not considered to render an individual medically unfit.

3-10. Hearing

a. Individuals on active duty who have an average hearing level in the better ear of 30 decibels or more, in the speech range, will be processed as outlined in AR 40-118 for further medical evaluation and disposition.

b. Individuals with an average hearing level in the better ear of 30 decibels or more whose hearing in the better ear cannot be improved by the use of a hearing aid to a level of 20 decibels or less in the speech reception score, are considered as medically unfit for further military service.

(1) Members on active duty will be processed through auditory screening centers as prescribed in AR 40-118.

(2) Members not on active duty will be disposed as outlined in paragraph 3-4*b*.

Section VI. ENDOCRINE AND METABOLIC DISORDERS

3-11. Endocrine and Metabolic Disorders

The causes of medical unfitness for further military service are—

a. Acromegaly: Severe with considerable incapacity after treatment.

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: Confirmed. Individuals on active duty, whose diabetes is mild, readily controlled by diet and/or hypoglycemic substances, who are of special value to the service, may be recommended for continuance on active duty. However, individuals manifesting retinopathy, intercapillary glomerulosclerosis, or other evidence of complicating involvement *will not* be continued.

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 malignant 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, usually preclude the satisfactory performance of military duty; such individuals are medically unfit for further military service.

g. Muscles:

(1) Flaccid paralysis of one or more muscles: More than moderate loss of function which precludes the satisfactory performance of duty following surgical correction or if not remediable by surgery.

(2) Spastic paralysis of one or more muscles: More than moderate with pronounced loss of function which precludes the satisfactory performance of military duty.

(3) Progressive muscular dystrophy: Confirmed.

h. Myotonia congenital: Confirmed.

i. Osteitis deformans (Paget's Disease): Involvement in single or multiple bones with resultant deformities or symptoms severely interfering with function.

j. Osteitisfibrosa cystica: Per se, does not render medically unfit.

k. 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.

l. Osteochondritis dissecans: Per se, does not render medically unfit.

m. Osteochondrosis: Including metatarsalgia and Osgood-Schlatter Disease per se *does not* render the individual medically unfit.

n. Osteomyelitis: When recurrent, not responsive to treatment, and involves the bone to a degree which severely interferes with stability and function.

o. Tendon Transplantation: Fair or poor restoration of function with weakness which seriously interferes with the function of the affected part.

p. Tenosynovitis: Per se, *does not* render the individual medically unfit.

Section VIII. EYES AND VISION

3-15. Eyes

The causes of medical unfitness for further 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 field of an eye to any degree when—

(1) The distant visual acuity in the unaffected eye cannot be corrected to 20/40 or better, or

(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 any cause.

d. Chronic congestive glaucoma.

e. Congenital and developmental defects do not per se, render the individual medically unfit.

f. 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.).

g. Diseases and infections of the eye: When chronic, more than mildly symptomatic, progressive, and resistant to treatment after a reasonable period.

h. Ocular manifestations of endocrine or metabolic disorders do not in themselves, render the individual medically unfit. However, the residuals or complications thereof or the underlying disease may render medically unfit.

i. Residuals or complications of injury to the eye which are progressive or which bring vision below the criteria in paragraph 3-16.

j. Retina, detachment of.

(1) Unilateral:

(*a*) When vision in the better eye cannot be corrected to at least 20/40,

(*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.

3-16. Vision

The causes of medical unfitness for further 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. Color blindness: Per se, *does not* render the individual medically unfit.

d. Loss of an eye: Per se. Individuals whose loss of an eye was due to other than progressive eye disease, who have a satisfactory prosthesis and who adjust well to the wearing of the prosthesis, may be recommended for continuance if they are of special value to the service.

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 20/40 in the better eye.

g. Visual field: Constricted to less than 20° in diameter.

Section IX. GENITOURINARY SYSTEM

3-17. Genitourinary System

(See also par. 3-18.)

The causes of medical unfitness for further military service are—

a. Albuminuria: Per se, *does not* render the individual medically unfit.

b. Cystitis: Per se, *does not* render the individual medically unfit. However, the residual symptoms or complications may in themselves render medically unfit.

c. Dysmenorrhea: Symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than one day.

d. Endometriosis: Symptomatic and incapacitating to a degree which necessitates recurrent absences of more than a day.

e. Enuresis: Per se, *does not* render the individual medically unfit. Recommend administrative separation, if appropriate.

f. Epididymitis: Per se, *does not* render the individual medically unfit.

g. Glycosuria: Per se, *does not* render the individual medically unfit.

h. 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.

i. Incontinence of urine: Due to disease or defect not amenable to treatment and of such severity as to necessitate recurrent absence from duty.

j. Kidney.

(1) Calculus in kidney: Bilateral, symptomatic and not responsive to treatment.

(2) Congenital anomaly of the kidney: Symptomatic and resulting in frequent or recurrent infections, or when there is evidence of obstructive uropathy.

(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 or pyelitis: Chronic, more than mild which has not responded to medical or surgical treatment, with evidence of hypertension, eye ground changes, or cardiac abnormalities.

(8) Pyonephrosis: More than minimal and not responding to treatment following surgical drainage.

(9) Nephrosis.

(10) Chronic glomerulonephritis.

(11) Chronic nephritis.

k. Menopausal syndrome, either physiologic or artificial: More than mild mental and constitutional symptoms.

l. Menstrual cycle irregularities including amenorrhea, menorrhagia, leukorrhea, metrorrhagia, etc., per se, do not render the individual medically unfit (*c* above).

m. Pregnancy: A confirmed diagnosis of pregnancy provides the basis for administrative separation in accordance with existing policies concerning pregnancy.

n. Sterility: Per se, does not render the individual medically unfit.

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

p. Urethritis, chronic, not responsive to treatment and necessitating frequent absences from duty.

q. Urinary bladder calculus or diverticulum does not render the individual medically unfit.

3-18. Genitourinary and Gynecological Surgery

The causes of medical unfitness for further military service are—

a. Cystectomy.

b. Cystoplasty: Reconstruction is unsatisfactory or if residual urine or infection persist.

c. Hysterectomy, per se, *does not* make the individual medically unfit; however, residual symptoms or complications may render the individual medically unfit.

d. Nephrectomy: Performed as a result of trauma, simple pyogenic infection, unilateral hydronephrosis, or nonfunctioning kidney when after the treatment period the remaining kidney is considered abnormal. 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 the concepts contained in paragraph 3-3.

e. Nephrostomy: If permanent drainage persists.

f. Oophorectomy: When following treatment and convalescent period there remain more than mild mental or constitutional symptoms.

g. Pyelostomy: If permanent drainage persists.

h. Ureterectomy: If the opposite kidney is abnormal.

i. Ureterocolostomy.

j. Ureterocystostomy: When both ureters were noted to be markedly dilated with irreversible changes.

k. Ureteroplasty:

(1) When unilateral operative procedure is unsuccessful and nephrectomy is resorted to, and the remaining kidney is abnormal after an adequate period of treatment.

(2) When the obstructive condition is bilateral the residual obstruction or hydronephroses must be evaluated on an individual basis by a genitourinary consultant and medical fitness for further military service determined in accordance with the concepts in paragraph 3-3.

l. Ureterosigmoidostomy.

m. Ureterostomy: External or cutaneous.

n. Urethrostomy: Complete amputation of the penis or when a satisfactory urethra cannot be restored.

o. Medical fitness for further 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

3-19. Head

(See also par. 3-30.)

Plating of the skull, loss of substance of the skull, and decompressions *do not* in themselves render the individual medically unfit. However, the residual neurologic signs and symptoms may render the individual medically unfit, see paragraph 3-31.

3-20. Neck

(See also par. 3-11.)

The causes of medical unfitness for further military service are—

a. Cervical ribs per se *do not* render the individual medically unfit.

b. 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

The causes of medical unfitness for further 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. Individuals on active duty, who recover from this condition without any residuals, signs, or symptoms may be recommended for continuance on active duty if they are of special value to the service and can be utilized in assignments on a worldwide basis.

f. Myocarditis and degeneration of the myocardium: Myocardial insufficiency at a functional level of Class IIC or worse, American Heart Association. See appendix VII.

g. Paroxysmal tachycardia, ventricular or atrial: Associated with organic heart disease or if not adequately controlled by medication.

h. Pericarditis:

(1) Chronic constrictive 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 within the definitions of functional Class IIC, American Heart Association. See appendix VII.

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 duties.

3-22. Vascular System

The causes of medical unfitness for further 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, unless satisfactorily treated by surgical correction.

c. Aneurysm of aorta. Individuals on active duty who have undergone successful surgical treatment and who are of special value to the service may be recommended for continuance on active duty.

d. Periarteritis nodosa, symptomatic.

e. Chronic venous insufficiency (post-phlebitic 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. Varicose veins: When more than mild in degree and symptomatic despite elastic support.

3-23. Miscellaneous

The causes of medical unfitness for further 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: Variable systolic

blood pressure with diastolic pressure consistently over 110-mm mercury in spite of adequate therapy, Grade II (Keith-Wagner-Barker) changes in the fundi, or more than minimal changes in the brain, heart, or kidneys.

d. Rheumatic fever, active, with or without heart damage: Recurrent attacks.

e. Residuals of surgery of the heart, pericardium, or vascular system resulting in inability of the individual to perform duties without discomfort or dyspnea.

Section XII. HEIGHT, WEIGHT, AND BODY BUILD

3-24. Height

Under-height or over-height: Per se, *does not* render the individual medically unfit.

3-25. Weight

Over-weight or under-weight: Per se, *does not* render the individual medically unfit. However, the etiological factor may in itself render the individual medically unfit.

3-26. Body Build

a. Obesity: Per se, *does not* render the individual medically unfit. However, the etiological factor in itself may render the individual medically unfit.

b. Deficient muscular development which is the result of injury or illness does not in itself render the individual medically unfit. However, as a residual or complication of injury or illness it may contribute to overall medical unfitness.

Section XIII. LUNGS AND CHEST WALL

3-27. Tuberculous Lesions

(See also par. 3-28.)

The causes of medical unfitness for further military service are—

a. Pulmonary tuberculosis except as stated below.

(1) Individuals on active duty will be held for definitive treatment when—

(*a*) The disease is service incurred.

(*b*) The individual's return to useful duty can be expected within 12 to 15 months, inclusive of a period of inactivity of 1 to 6 months or more. See TB Med 236.

(2) Members of the Reserve components, not on active duty will be found fit for retention in this status, not subject to call to active duty for training, inactive duty training, or mobilization for a period not to exceed 12 to 15 months when the individual will be capable of performing full time useful military duty within 12 to 15 months with appropriate treatment, inclusive of a period of inactivity of 6 months or more. See TB Med 236.

b. Tuberculous empyema.

c. Tuberculous pleurisy: Same as pulmonary tuberculosis (*a* above).

3-28. Nontuberculous Lesions

The causes of medical unfitness for further military service are—

a. Asthma: Associated with emphysema of sufficient degree to interfere with performance of duty or frequent attacks 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: Cylindrical or saccular type which is moderately symptomatic, with or without paroxysmal cough at frequent intervals throughout the day, mild emphysema, recurrent pneumonia, loss in weight, or frequent hospitalization.

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 defect: Symptomatic.

g. Hemopneumothorax, hemothorax and pyopneumothorax: More than moderate pleuritic residuals with persistent underweight, marked restriction 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 to 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: Not responding to therapy or complicated by residual pulmonary insufficiency.

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.

q. Stenosis, trachea.

3-29. Surgery of the Lungs and Chest

The causes of medical unfitness for further military service are—

Lobectomy: If pulmonary function is seriously impaired or if performed for malignancy.

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

3-30. Mouth, Nose, Pharynx, Trachea, Esophagus, and Larynx

The causes of medical unfitness for further 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 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 the individual to have difficulty in maintaining weight and nutrition, when the condition does not respond 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 parasinusitis.

e. Sinusitis: Severe, chronic sinusitis which is suppurative, complicated by polyps, and which does not respond to treatment.

★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. Miltary 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 (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 other than the fifth (little) finger.

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 calluses 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 uniformily 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.

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, chapter 3.

b. Anophthalmia 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, chapter 3.

b. Chronic prostatitis or hypertrophy of prostate, with evidence of urinary retention.

c. Kidney: Absence of one kidney when there is progressive disease or impairment of function in the remaining kidney.

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, chapter 3.

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 Medical and Dental Registrants are—

a. Paragraphs 3-21, 3-22, and 3-23, chapter 3.

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. 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.

e. 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.

f. Valvular heart disease: Known or demonstrated valvular heart disease.

g. Varicose veins associated with ulceration of the skin, symptomatic edema, or recurring incapacitating dermatitis.

h. Rheumatic fever: The residuals and chronicity of the diseases are the determining factors for acceptability. An individual is unacceptable if there are definite residuals involving the heart or if there is a verified history of recurrent attacks or cardiac involvement 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, chapter 3.

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, chapter 3.

b. Bronchial asthma, more than mild or seasonal and not readily controlled by oral medications or by desensitization.

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, cystic, 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 Medical and Dental Registrants are—

a. Paragraph 3–30, chapter 3.

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 Medical and Dental Registrants are the causes listed in paragraph 3–31, chapter 3.

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, chapter 3.

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. Standard Forms 88 and 89 and neuropsychiatric consultation 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. Standard Forms 88 and 89 and neuropsychiatric consultation will be sent to The Surgeon General, ATTN: MEDPS–SP, Department of the Army, for an opinion of acceptability prior to qualification.

MEDICAL CONDITION – PHYSICAL PROFILE RECORD
(AR 40-501)

DATE: 1 Jul 61

TO: Commanding Officer
Co B, 555 Engr-Constr Bn
APO 58
% Postmaster, New York, New York

FROM: Commanding Officer
34th General Hospital
APO 58
% Postmaster, New York, New York

LAST NAME - FIRST NAME - MIDDLE INITIAL, GRADE, SERVICE NO. 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	✓	INDIVIDUAL IS RETURNED TO YOUR UNIT FOR DUTY *(AR 40-212, AR 635-40B, as applicable)*
2		INDIVIDUAL IS RETURNED TO YOUR UNIT FOR SEPARATION PROCESSING *(AR 40-212, AR 635-40B, as applicable)*
3	✓	INDIVIDUAL (IS) ~~(IS NOT)~~ MEDICALLY QUALIFIED FOR duty with Government assignment limitation AS EVIDENCED BY A MEDICAL EXAMINATION AND A REVIEW OF HIS HEALTH RECORD THIS DATE

SECTION B - PHYSICAL PROFILE
(Complete all items. When applicable "R" or "T" will be entered with numerical designator under appropriate factor)

		P	U	L	H	E	S	
4	PREVIOUS	1	1	1	1	1	1	PREVIOUS
5	PRESENT	3	1	1	1	1	1	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)*

Stomach ulcer

☐ *Continued under remarks*

SECTION C - ASSIGNMENT RESTRICTIONS, OR GEOGRAPHICAL, OR CLIMATIC AREA LIMITATIONS *(Check Applicable Items(s))*

7		INDIVIDUAL REQUIRES NO MAJOR ASSIGNMENT, GEOGRAPHICAL, OR CLIMATIC AREA LIMITATIONS
8	✓	MAJOR ASSIGNMENT, GEOGRAPHICAL, OR CLIMATIC AREA LIMITATIONS ARE ESTABLISHED BELOW *(AR 40-212, AR 40-501, AR 635-40B, as applicable. Describe specific assignment limitations or restrictions as outlined in Chapter 9, AR 40-501.)*

No assignment to units requiring continued consumption of combat rations

☐ *Continued under remarks*

9	✓	THE ABOVE CONDITIONS ARE PERMANENT
10		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 40-212, AR 40-501 as applicable)*
11		SEPARATION OR RETIREMENT OF THIS INDIVIDUAL WILL NOT BE EFFECTED WITHOUT PRIOR MEDICAL EVALUATION *(AR 40-212, AR 40-501, AR 616-41, as applicable)*
12	✓	THIS SUPERSEDES PREVIOUS MEDICAL CONDITION - PHYSICAL PROFILE RECORDS

13. TYPED NAME & GRADE OF AUTHORIZED OFFICER AT MEDICAL FACILITY	SIGNATURE

DA FORM 1 FEB 62 8-274

Figure 9-1.

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		2 Jul 61

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 amunition, vehicle driving, work near moving machinery.
J - No firing of weapons or exposure to loud noises.
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 1

GENERAL PROVISIONS

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

Section I. INTRODUCTION

1-1. Purpose

These regulations set forth the medical fitness standards considered necessary 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 these regulations 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. Provide medical fitness standards of sufficient detail to insure greater uniformity in the medical evaluation of examinees.

Section II. CLASSIFICATION

1-3. Medical Classification

Individuals evaluated under the medical fitness standards contained in these regulations 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 these regulations 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 1-4*c* 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.

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(2) Degenerations of the retina to include macular diseases, macular cysts, holes, and other degenerations (hereditary or acquired) affecting the macula 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 Coats' 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 diopters deviation or more.

(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) Color blindness, severe, with inability to distinguish bright red from bright green.

(5) Exophthalmos, unilateral or bilateral.

(6) Glaucoma, primary or secondary.

(7) Hemianopsia of any type.

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

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

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

(11) Residuals of old contusions, lacerations, penetrations, etc., which impair visual function required for satisfactory performance of military duty.

(12) Retained intra-ocular foreign body.

(13) Tumors. See *a*(6) above and paragraphs 2–40 and 2–41.

(14) 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 not correct 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–4 (20/30).

c. Refractive error: High degree of refractive error (especially a spherical equivalent of over

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−8.00 or +8.00) when ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement, etc., or ophthalmological consultation reveals contraindication to military service.

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 pars. 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 below.

h. New growths of the internal or external genitalia except single uterine fibroid, subserous, asymptomatic, less than 3 centimeters in diameter, with no general enlargment 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 pars. 2-40 and 2-41.):

(1) Absence or non-descent of both testicles.

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

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 chonic.

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 pars. 2-8, 2-40, and 2-41.)

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

a. Albuminuria including so-called orthostatic or functional albuminuria, other than that produced by obvious extrarenal disease.

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

c. Enuresis subsequent to the age of 8. See also paragraph 2-34*c*.

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 rental 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) Hydronephrosis or pyonephrosis.

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 60 inches or over 72 inches.

b. For enlistment and induction.

(1) *Men.* Height below 60 inches or over 78 inches.

(2) *Women.* Height below 60 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.

2-23. Body Build

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

a. Congenital malformation of bones and joints. (See pars. 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, 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 par. 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 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 preceding 5 years.

q. Sarcoidosis.

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.

(2) Refractive error:

(*a*) Hyperopia: 5.00 diopters.

(*b*) Myopia: 3.00 diopters.

b. Individuals who have have been designated as Distinguished Military Graduates of the Army ROTC accepting Regular Army commissions or who are graduates of the U.S. Military Academy will automatically be considered for an administrative waiver by Headquarters, Department of the Army during the processing of their cases for assignment to Armor, Artillery, Infantry, Corps of Engineers, Signal Corps, or Military Police Corps, if they meet the following:

(1) Distant visual acuity: Any degree of uncorrected visual acuity which corrects to 20/20 in both eyes.

(2) Refractive error:

(*a*) Hyperopia: 5.50 diopters.

(*b*) Myopia: 5.50 diopters.

(*c*) Astigmatism: 3.00 diopters.

(*d*) Anisometropia: 3.50 diopters.

★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

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	135	137	140	138	135	135
59	93	137	139	144	140	139	138
60	96	139	141	147	142	142	141
61	99	141	144	150	144	145	141
62	102	144	147	154	147	148	147
63	105	150	152	157	152	151	150
64	109	152	155	160	155	155	154
65	112	155	160	164	161	159	158
66	115	160	165	168	166	164	163
67	119	163	168	173	171	168	167
68	122	169	175	177	176	172	171
69	125	175	178	182	180	176	175
70	128	181	184	186	185	181	180
71	131	186	190	191	190	185	184
72	135	191	194	195	194	189	188

Table III. Table of Acceptable Weight (in Pounds) as Related to Age and Height for Army Aviation

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	146	150	153	157	160	164
61	102	149	153	155	159	163	166
62	103	151	155	158	161	165	169
63	104	155	159	160	164	168	171
64	105	159	160	164	168	171	175
65	106	163	165	169	173	176	180
66	107	166	170	174	178	181	185
67	111	171	175	179	183	186	190
68	115	176	180	184	188	191	195
69	119	181	185	189	193	196	200
70	123	186	190	194	198	200	200
71	127	191	195	199	200	200	200
72	131	196	200	200	200	200	200
73	135	200	200	200	200	200	200
74	139	200	200	200	200	200	200
75	143	200	200	200	200	200	200
76	147	200	200	200	200	200	200

Table IV. Table of Acceptable Weight (in Pounds) as Related to Height for Diving Duty

Height (inches)	Minimum	Maximum
	Regardless of age	Regardless of age
60	100	139
61	100	143
62	100	146
63	100	150
64	102	154
65	106	158
66	109	163
67	112	168
68	115	173
69	118	178
70	122	182
71	125	187
72	128	192
73	131	197
74	135	202
75	138	206
76	141	211
77	144	216
78	147	221

Table III. Table of Acceptable Weight (in Pounds) as Related to Age and Height for Army Aviation

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	146	150	153	157	160	164
61	102	149	153	155	159	163	166
62	103	151	155	158	161	165	169
63	104	155	159	160	164	168	171
64	105	159	160	164	168	171	175
65	106	163	165	169	173	176	180
66	107	166	170	174	178	181	185
67	111	171	175	179	183	186	190
68	115	176	180	184	188	191	195
69	119	181	185	189	193	196	200
70	123	186	190	194	198	200	200
71	127	191	195	199	200	200	200
72	131	196	200	200	200	200	200
73	135	200	200	200	200	200	200
74	139	200	200	200	200	200	200
75	143	200	200	200	200	200	200
76	147	200	200	200	200	200	200

Table IV. Table of Acceptable Weight (in Pounds) as Related to Height for Diving Duty

Height (inches)	Minimum	Maximum
	Regardless of age	Regardless of age
60	100	139
61	100	143
62	100	146
63	100	150
64	102	154
65	106	158
66	109	163
67	112	168
68	115	173
69	118	178
70	122	182
71	125	187
72	128	192
73	131	197
74	135	202
75	138	206
76	141	211
77	144	216
78	147	221

s/s c1
5 Ch. 1 10 Feb 1967

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CHAPTER 1

GENERAL PROVISIONS

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

Section I. INTRODUCTION

1-1. Purpose

These regulations set forth the medical fitness standards considered necessary of persons in the military service and of medical and dental registrants who are candidates for military service under the Universal Military Training and Service Act, as amended, in terms of medical conditions and physical defects which are causes for rejection or medical unfitness for military service.

1-2. Objectives

The objectives of these regulations are to—

a. 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.

b. 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 may have physical defects or medical conditions, which would ordinarily be cause for rejection into the military service.

c. Provide medical fitness standards of sufficient detail to insure greater uniformity in the medical evaluation of examinees.

CHAPTER 2

(To be published at a later date)

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 medical conditions and physical defects which, upon detection, make an individual medically unfit for further military service. This includes medical examinations accomplished at any time such as—

a. Periodic.

b. Promotion.

c. Active duty, active duty for training, inactive duty training, and mobilization of units and members of the Reserve components of the Army.

d. Reenlistment within 90 days of separation.

e. Separation including retirement.

3-2. Applicability

a. These standards apply to the following regardless of grade, branch of service, MOS, age, length of service, component, or service connection:

(1) All personnel on active duty including active duty for training.

(2) All members of the Army National Guard of the United States, not on active duty.

(3) All members of the Army Reserve, not on active duty, except members of the Retired Reserve.

(4) Personnel approved for continuance (waiver) under AR 616-41, AR 140-120, and NGR 27, except for medical conditions and physical defects for which continuance has been approved. These standards will apply upon termination (or withdrawal) of continuance under AR 616-41, AR 140-120, or NGR 27.

b. These standards *do not apply* in the determination of an individual's medical fitness for Army Aviation, Airborne, Marine Diving, Ranger, or other assignments or duties having different medical fitness standards for retention therein.

3-3. Evaluation of Physical Disabilities

a. An individual will not be declared medically unfit for further military service (par. 3-1) under these standards because of disabilities which were known at the time of initial acceptance for military service or continuance under AR 616-41, AR 140-120, or NGR 27 when the medical condition or physical defect is essentially unchanged and has not interfered with the individual's successful performance of duty.

b. These standards take into consideration the individual's medical fitness to perform satisfactory military duty; the nature, degree, and prognosis of the condition or defect; and the effect of continued service in the military environment upon the health of the individual. Most members possess some physical imperfections which, although rateable in the Veterans Administration Schedule for rating disabilities, do not, per se, preclude the individual's satisfactory performance of military duties. The presence of physical imperfections whether or not they are rateable, should routinely be made a matter of record whenever discovered.

c. Lack of motivation for service should not influence the medical examiner in evaluating disabilities under these standards. Poorly motivated individuals who are medically fit for duty will be recommended for administrative disposition.

3-4. Disposition of Personnel Who Are Medically Unfit Under These Standards

a. Individuals on active duty including active duty for training who are medically unfit under these standards will be processed for disability separation (including retirement) in accordance with the procedures contained in AR 40-212, AR 635-40A, and AR 635-40B for the purpose of determining their eligibility for physical disability benefits under title 10, United States Code, chapter 61 (formerly title IV, Career Compensation Act of 1949) or for continuance on active duty with deferment of disability separation (waiver) as outlined in AR 616-41.

b. Individuals *not on active duty* who are medically unfit under these standards will be administratively processed in accordance with AR 140-120, NGR 25-3, or NGR 62, as appropriate, for disability separation or continuance in Reserve component status (waiver) as prescribed therein. Individuals who become medically unfit under these standards by reason of injury incurred during a period of inactive duty training will be processed as prescribed in AR 40-212.

c. Active duty personnel who are *administratively unfit* for retention will be processed in accordance with the procedures contained in appropriate administrative regulations such as AR 635-89, AR 635-105A, AR 635-105B, AR 635-206, AR 635-208, and AR 635-209.

Section II. ABDOMEN AND GASTROINTESTINAL SYSTEM

3-5. Abdominal and Gastrointestinal Defects and Diseases

The causes for medical unfitness for further military service are—

a. Achalasia (Cardiospasm): Dysphagia not controlled by dilatation, with continuous discomfort, or inability to maintain weight.

b. Amebic abscess residuals: Persistent abnormal liver function tests after appropriate treatment.

c. Biliary dyskinesia: Frequent abdominal pain not relieved by simple medication, or with periodic jaundice.

d. Cirrhosis of the liver: Recurrent jaundice, ascites, or demonstrable esophageal varices or history of bleeding therefrom; failure to maintain weight and normal vigor.

e. Gastritis: Severe, chronic hypertrophic gastritis with 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: Symptoms not relieved by simple dietary or medical means, or recurrent bleeding in spite of prescribed treatment.

(2) If operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

h. Ileitis, regional: Confirmed diagnosis thereof. However, individuals on active duty who are able to maintain weight, have no significant abdominal pain, have no signs of anemia, average no more than 4 bowel movements per day, have a good understanding of the disease, who do not require frequent medical attention and who are of special value to the service may be recommended for continuance on active duty.

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 with repeated admissions to the hospital.

l. Ulcer, peptic, Duodenal and gastric: Frequent recurrence of symptoms (pain, vomiting, and bleeding) in spite of good medical management and supported by laboratory and X-ray evidence.

m. Ulcerative colitis: Confirmed diagnosis

CHAPTER 4

(To be published at a later date)

CHAPTER 5

(To be published at a later date)

CHAPTER 6

(To be published at a later date)

CHAPTER 7

(To be published at a later date)

APPENDIX I

(To be published at a later date)

APPENDIX II

(To be published at a later date)

APPENDIX III

(To be published at a later date)

APPENDIX V

(To be published at a later date)

APPENDIX VI

(To be published at a later date)

REFERENCE

Headquarters
Department of the Army
Washington, D. C.
1 November 1985

Immediate Action
INTERIM CHANGE

AR 40-501
INTERIM CHANGE
No. I02
Expires 1 November 1987

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Justification. This interim change is necessary to comply with a memorandum from the Deputy Secretary of Defense, subject HTLV-III Testing, dated 30 August 1985, which in part states, "To protect the health of military personnel all potential accessions will be screened for HTLV-III antibody by a Food and Drug Administration approved enzyme immunoassay (EIA) serologic test and, if positive, an immunoelectrophoresis (Western blot) test." The memorandum also states that, "This policy is effective immediately and it should be implemented as soon as possible, but not later than October 1, 1985."

Expiration. This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

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

Page 2-1. The following sentence is added at the end of paragraph 2-2a(8):

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

Page 2-18. Subparagraph m is added to paragraph 2-39.

m. Presence of HTLV-III virus or antibody. Presence is confirmed by repeatedly reactive Enzyme-linked Immunoassay (ELISA) Serologic tests and positive Immunoelectrophoresis (Western Blot) test.

Page 8-5. Subparagraph d is added to paragraph 8-23:

d. The cause listed in paragraph 2-39m (applies only for the purposes of paragraph 8-2a(1), (2), and (3)).

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Page A9-5 . The following explanatory note is added after the "Sickle Cell... electrophoresis....sickle tests have...." note in item 50.

Type A and Type B Examinations; Immunoassay (ELISA) Serologic Test and Immunoelectrophoresis (Western Blot) Test--Record as HTLV-III Antibody Positive (Western Blot confirmed), HTLV-III Antibody Positive (Western Blot not confirmed) or HTLV-III Antibody Negative. These tests must be accomplished on all medical examinations administered for initial entrance into active and reserve component military service including enlistment or induction; entrance into a service academy, 4-year ROTC scholarship, Uniformed Services University of the Health Sciences, and Advanced Course Army ROTC, and direct appointment of commissioned and warrant officers from civilian sources.

2. Post this change per DA Pam 310-13.

3. File this interim change in front of the publication.

(DASG-PSP-O)

By Order of the Secretary of the Army:

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

Official:

MILDRED E. HEDBERG
Brigadier General, United States Army
The Adjutant General

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EFERENCE

Headquarters
Department of the Army
Washington, D. C.
15 April 1986

Immediate Action
INTERIM CHANGE

AR 40-501
INTERIM CHANGE
No. 103
Expire 15 April 1987

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Justification. This interim change is necessary to comply with a memorandum from the Assistant Secretary of Defense (Health Affairs), subject Policy on Evaluation, Staging and Disease Coding of Military Personnel Infected with Human T-Lymphotrophic Virus Type III (HTLV-III), dated 6 January 1986, and the subsequent policy letter from The Adjutant General, Department of the Army, subject Policy for Identification, Surveillance, and Disposition of Personnel Infected with Human T-Lymphotrophic Virus Type III (HTLV-III), dated 1 February 1986.

Expiration. This interim change expires 1 year from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

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

Page 3-4.2. Subparagraph h is added to paragraph 3-7.

h. HTLV-III confirmed antibody positivity, with the presence of progressive clinical illness or immunological deficiency (Walter Reed Staging Classification Level 5 or 6). For RA soldiers, and Reserve Component (RC) soldiers on active duty for more than 30 days (except for evaluation under the Walter Reed staging system or for training UP 10 U.S.C. 270(b)), a Medical Evaluation Board (MEBD) must be accomplished and, if appropriate, the soldier must be referred to a Physical Evaluation Board (PEB) per AR 635-40. For RC soldiers not on active duty for more than 30 days or on active duty for training UP 10 U.S.C. 270(b), convening of a MEBD and referral to a PEB will be determined per chapter 8, AR 635-40. Records of official diagnoses provided by private physicians (i.e., civilian doctors providing evaluations under contract with DA/DoD, or civilian public health officials) concerning the presence of progressive clinical illness or immunological deficiency in RC soldiers may be used as a basis for administrative action under, for example, AR 135-133, AR 135-175, AR 135-178, AR 140-10, NGR 600-200, or NGR 635-100, as appropriate.

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2. Post this change per DA Pam 310-13.

3. File this interim change in front of the publication.

(DASG-PSC-B)

By Order of the Secretary of the Army:

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

Official:

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

DISTRIBUTION:

Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A requirements for AR, Medical Services (Applicable to Medical Activities Only)--A. Active Army, ARNG, USAR: Medical Services (Applicable to all Army Elements)--B.

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REFERENCE

Headquarters
Department of the Army
Washington, DC
14 March 1985

Immediate Action
INTERIM CHANGE

AR 40-501
INTERIM CHANGE
NO. I01
Expires 14 March 1987

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Justification. This interim change is necessary to comply with a memorandum from The Deputy Secretary of Defense dated 25 January 1985 which states, "Despite considerable research, the role of sickle cell trait as a significant risk factor in certain types of military duties (especially flying and diving) has not been demonstrated. Accordingly, all military occupational specialty restrictions on SCT bearers are to be removed, effective immediately. Further, such individuals are not to be subjected to any additional screening or physiological testing beyond that required for all candidates for that occupation. If an individual, under the usual operational conditions of the person's military specialty, develops a significant physiological event as the result of SCT which places him or her at risk for additional episodes, the individual may be disqualified from further such duties."

Expiration. This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner superseded by a formal printed change; is, as an interim measure, issued in other than page-for-page format; and will be included in the next change to AR 40-501.

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

Page 4-4. Paragraph 4-5 is superseded as follows:

4-5. Blood and Blood-Forming Tissue Diseases

The causes of medical unfitness for flying duty Classes 1, 1A, 2, and 3 are the causes listed in paragraph 2-4.

Page 7-1. Paragraph 7-3b(3) is rescinded.

Page 7-3. Paragraph 7-5b(4) is rescinded.

Page 7-4. Paragraph 7-8b(3) is superseded as follows:

(3) Sickle cell disease.

Page 7-6. Paragraph 7-10b(2) is superseded as follows:

(2) Sickle cell disease.

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2. Post this change per DA Pam 310-13.

3. File this interim change in front of the publication.

(DASG-PSP-O)

By Order of the Secretary of the Army:

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

Official:

DONALD J. DELANDRO
Brigadier General, United States Army
The Adjutant General

DISTRIBUTION:

Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A requirements for AR, Medical Services (Applicable to Medical Activities only)--A. Active Army, ARNG, USAR: Medical Services (Applicable to all Army Elements)--B.

*U.S. GOVERNMENT PRINTING OFFICE: 1985-461-029:10137

REFERENCE S/S Ch. 34 1 Dec 1983

Immediate Action
INTERIM CHANGE

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 8 March 1983

AR 40-501
*INTERIM CHANGE
NO. I06
Expires 8 March 1984

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

Justification. This interim change implements policies and procedures contained in AR 600-9 requiring all personnel over 40 years of age to be medically screened for participation in the Army's Physical Fitness Training Program; it also modifies portions of Chapter 2, Medical Fitness Standards for Appointment, Enlistment, and Induction; Chapter 10, Medical Examinations--Administrative Procedures; Appendix II, Tables of Acceptable Audiometric Hearing Level; Appendix VIII, Physical Profile Functional Capacity Guide; and Appendix IX, Scope and Recording of Medical Examinations. This interim change includes and updates all information contained in all previously published and expired interim changes since C32, 15 August 1980. These changes have been made to prevent loss of life and personal injury. Medical reports generated as a result of the medical screening required by this change are exempt from management information requirements in accordance with paragraph 5-2b(8), AR 335-15.

Expiration. This interim change expires 1 year from date of publication and will be destroyed at that time unless sooner superseded by a formal printed change; is being distributed by 1st class mail through the publication pinpoint distribution system to all holders of AR 40-501; is, as an interim measure, issued in other than page-for-page format; and will be included in the next change to AR 40-501.

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

Page 2-15. Paragraph 2-31d is superseded as follows:

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

(1) No seizure since age 5.

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

*This interim change supersedes Change I05, 16 April 1982.

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Page 10-9. Paragraph 10-23c, a new subparagraph (1) is added as follows:

c. Frequency.

(1) General Officers.

(a) All General Officers on active duty will undergo an annual medical examination within 3 calendar months before the end of the birthday month (Type B for those who are aviators, Type A for all others). In addition to the scope of the examination prescribed by appendix IX, the cardiovascular screening prescribed in paragraph 10-31 will be accomplished. Examinations will be scheduled on an individual appointment basis and accomplished on an outpatient or inpatient basis, depending upon the professional judgment of the examining physician(s). Additional tests/diagnostic procedures in excess of the prescribed scope of the examination will be accomplished when, in the opinion of the examining physician(s), such procedures are indicated.

(b) The annual dental examination prescribed by AR 40-3 will, as far as practicable, also be accomplished.

(c) Immunization records will be reviewed and required immunizations will be administered (AR 40-562).

Pages 10-9 and 10-10, subparagraphs 10-23c(1) through (10). Renumber to read subparagraphs 10-23c(2) through (11).

Page 10-10. Paragraph 10-23d is superseded as follows:

d. Reporting of medical conditions.

(1) Reporting of the results of periodic medical examinations pertaining to active Army members age 40 and over will be accomplished as prescribed in paragraph 10-31.

(2) Any change in physical profile or limitations found on periodic medical examinations will be reported to the unit commander on DA Form 3349 (Physical Profile Board Proceedings) as prescribed in chapter 9.

(3) Retired personnel will be informed of the results of medical examinations by the examining physician, either verbally or in writing. A copy of the SF 88 may be furnished on request on an individual basis.

Pages 10-10 and 10-11. Paragraph 10-25a is superseded as follows:

a. There is no statutory requirement for members of the active Army (including USMA cadets and members of the USAR and ARNG on active duty or active duty for training) to undergo a medical examination incidental to

separation from active Army service. However, except for members retiring after more than 20 years of active service, it is Army policy to accomplish a medical examination if the member requests it.

(1) Active Army members retiring after more than 20 years active duty are required to undergo a medical examination prior to retirement. Results of that examination will be reported as indicated in paragraph 10-31.

(2) The following schedule of separation medical examinations is established:

	Required	Not required	Can be requested by member (in writing)
Retirement after 20 or more years of active duty.	X*		
Retirement from active service for physical disability, permanent or temporary, regardless of length of service.	X*		
Expiration of term of active service (separation or discharge, less than 20 years of service).		X	X
Upon review of Health Record, evaluating physician or physician assistant (PA)** at servicing MTF determines that, because of medical care received during active service, medical examination will serve best interests of member and Government, e.g., hospitalization for other than diagnostic purposes within 1 year of anticipated separation date.	X*		
Individual is member of Army National Guard on active duty or active duty for training in excess of 30 days.		X	X
Individual is member of Army National Guard and has been called into Federal service (10USC3502).	X*		

*See footnotes at end of table.

	Required	Not required	Can be requested by member (in writing)
Deserters who return to military control and are being processed for judicial or administrative discharge except discharge under chapter 10 or section V, chapter 14 of AR 635-200.	X*		
Prisoners of war, including internees and repatriates, undergoing medical care, convalescence or rehabilitation, who are being separated.	X*		
Officers, WOs and enlisted members previously determined eligible for separation or retirement for physical disability but continued on active duty after complete physical disability processing (chapter 6, AR 635-40 and predecessor regulations).	X (Plus MEB and PEB)		
Officers, WOs and enlisted members previously processed for physical disability (AR 635-40) and found fit for duty with one or more numerical permanent designators "4" in physical profile serial.	X*		
All officers, WOs and enlisted members with one or more temporary numerical designators "4" in physical profile serial.	X*		
Officers and WOs being processed for separation under provisions of sections XV, XIX, XXVIII of chapter 3, and section IV of chapter 5, AR 635-100; chapters 4, 5, 7, 10, 12, 16, AR 635-120.	X*		
Officers and WOs separated under provisions of AR 635-100 and AR 635-120 other than listed.		X	X
Enlisted members being processed for separation under provisions of paragraphs 5-3, 5-6 and 5-14 of chapter 5, section III of chapter 8, chapter 9, paragraph 14-23, section IV of chapter 14, AR 635-200.	X		

*See footnotes at end of table.

	Required	Not required	Can be requested by member (in writing)
Enlisted members being processed for separation under provisions of chapter 13, AR 635-200 (both mental evaluation and medical examination required).	X		
Enlisted members being processed for separation under provisions of section V of chapter 14, and chapter 15, AR 635-200. (Mental status evaluation only is required. Medical examination may be requested by member in writing and, if so requested, should be accomplished expeditiously without regard to time constraints otherwise applicable in this paragraph to voluntary examination.)			X
Enlisted members being processed for separation under provisions of chapter 10, AR 635-200. (If medical examination is requested by member, then mental status evaluation is required.)			X
Discharge in absentia (officers and enlisted members):			
Civil confinement		X	
When BCD or DD is upheld by appellate review and individual is on excess leave		X	
Deserters who do not return to military control		X	
Enlisted members being processed for separation under all other provisions of AR 635-200 not listed above.		X	X

*Examination will be accomplished not earlier than 4 months, nor later than 1 month prior to scheduled date of retirement discharge, relief from active duty or active duty for training.

**PAs may review health records of officers, WOs and enlisted members upon expiration of term of service (separation or discharge) if such authority has been designated to them by the supervising physician and approved by the MTF commander or unit staff surgeon.

Page 10-18. Paragraph 10-31 is added as follows:

10-31. Medical Evaluation -- Army Physical Fitness and Weight Control Program for Active Members Age 40 and Over.

a. Criteria. The routine medical examinations will be utilized as a vehicle for accomplishing the initial cardiovascular screening for personnel 40 years of age and over prior to entry into the Army Over-40 Physical Fitness Program. Personnel age 40 and over shall not be required to begin a physical training program or be tested prior to cardiovascular screening. This does not exempt personnel from performing normal MOS physical tasks. The procedures to be followed in screening for coronary heart disease will result in calculation of an overall risk index. This risk index will be based on tables derived from the Framingham Study on heart disease which combines input from 7 risk factors to include age, sex, smoking habit, systolic blood pressure, resting ECG for left ventricular hypertrophy, carbohydrate intolerance, and cholesterol.

(1) Additional secondary screening will be required for those who:

(a) Possess a relatively high risk index of 5% or greater.

(b) Have a clinical cardiovascular finding:

1. Have a history suggesting angina pectoris discomfort, dyspnea, syncope, palpitation, hypertension, drug treatment of hypertension, or a family history of a clinical coronary event (angina pectoris, myocardial infarction, sudden death due to natural causes, etc.) in a first-order relative (parent or sibling) age 50 or younger.

2. Have a cardiovascular abnormality on physical examination such as persistent hypertension, cardiomegaly, murmur, etc.

(c) Have any abnormality on ECG.

(d) Have a fasting blood sugar of 115 mg % (mg/dl) or over (carbohydrate intolerance).

(2) Personnel who have none of the above factors may be cleared to enter directly into this program. Those who require additional screening may be subsequently cleared and enter the program or may require an individualized program prescribed by the consulting physician.

(3) Personnel 40 years of age or over who are already in training may maintain their current level of exercise until they undergo medical screening and, if cleared, can advance to greater levels of exercise activity. Testing may be accomplished 3 months after cardiovascular screening results in clearance for participation in the program.

b. Implementation. Implementation of the screening to reach all personnel already age 40 or over will require a special schedule for medical examination. All such members will receive a complete medical examination during the month of birth at age 40, 42, 44, etc. This will allow such members to be screened within a period of approximately 2 years from the date of inception of this program, 30 June 1981. Personnel will be identified for the periodic medical examination and screening for this program and notified through procedures prescribed in DA Pamphlet 600-8. The cardiovascular screen will thereafter be administered to all members age 40 or over at the

time of each periodic medical examination at 5-year intervals (see para 10-23c) and during retirement medical examination except when a prior over-40 screen has not been done. The retirement medical examination will henceforth be mandatory (see para 10-25a). Members currently under age 40 will have a medical examination including cardiovascular screening upon attaining age 40 even if involved in a training program at the time. The cardiovascular screen will be a regular part of every medical examination after age 40.

(1) Commanders at all levels will be responsible for insuring that all personnel over 40 years of age are screened and subsequently participate in the Physical Fitness Training or a modified program as prescribed by consulting physician.

(2) Commanders at Medical Centers and MEDDACs will be responsible for implementing procedures established in this regulation. This will require involvement of the Chiefs of Ambulatory Care and Department of Medicine in scheduling and processing examinations in a timely manner. Local commanders must be briefed on the capabilities of the medical facility and the time frame necessary for completion of the screening for all personnel. A continued review will be necessary to insure accuracy of data collected and full participation by all personnel.

c. Data Processing. A central registry for monitoring, evaluating, and record keeping at the Armed Forces Institute of Pathology (AFIP) will be part of the program. Close coordination and feedback between personnel records offices and medical examining facilities will be necessary to insure success of this critical element of the program.

(1) The DA Form 4970 (Medical Screening Summary--Over-40 Physical Fitness Program) has been designed as a single form to accomplish all record keeping and data transmittal in this program. (See fig. 10-4 for sample form.) Data obtained in the initial screen will be typed on the front of this form and forwarded to the AFIP where a risk index will be calculated to assist the examining facility in decision-making. Calculation results and recommendations will be printed in the "For AFIP Use Only" section and returned to the examining facility for processing. The Medical Examining Section will be responsible for processing the examination results and DA Form 4970. A suspense file will be necessary to verify return receipt of all forms which have been forwarded to AFIP. Each time the examination results are forwarded to the AFIP, they will be processed and the form expeditiously returned to the original examining facility. For those personnel who are not cleared, a draft SF 513 (Medical Record--Consultation Sheet) will be prepared and returned with DA Form 4970 to help accomplish a secondary screen. When the secondary screen is completed the results will be entered in a space prepared by the computer in the "For AFIP Use Only" section. The original form will be returned to AFIP. The AFIP will return the form to the examining station for filing as a permanent part of the individual health record when all screening has been completed. A new form should never be initiated at any point in the screening process unless the original has been lost.

(2) Recording the cardiovascular screening and determining clearance for the physical training program will be accomplished on DA Form 4970 and entered on SF 88 (item 73. NOTES) as follows: Favorable or Unfavorable. All required information will be recorded on the original copy of DA Form 4970 and forwarded to the AFIP for record keeping, regardless, if local physicians determine eligibility for training and testing. The original copy will be processed by ADP optical readers which will be utilized for timely processing and recording of all data. The process for decision-making is outlined within this section. It is sufficiently straightforward to permit local determination with assistance from the reference cited in para g(3)(b) below.

(3) The cardiovascular screening program is designed for integration with the periodic medical examination. Mass screening will not be done because the quality of the screening examination will suffer and mass screening will overload the medical system. Local commanders will have latitude in increasing the number of physicals done in the examining station, where feasible, and thus accelerate the completion of the screening. Commanders are reminded that medical examination and followup screening specialty clinics cannot handle excessive screening loads while continuing to support the medical care mission.

d. Screening instructions.

(1) The cardiovascular screen will be based on the 7 risk factors taken from the Framingham Study. Virtually all of these risk factors are now being measured in the routine periodic medical examination. The 7 risk factors will be used to calculate a risk factor index as outlined by the American Heart Association Publication 70-003-A, Coronary Risk Handbook. A risk factor index of 5% or greater likelihood of developing coronary heart disease in 6 years will require the member to undergo further medical testing within regular medical channels before clearance is given for participation in the program.

(2) Three additional related factors will be addressed at the time of the initial examination: positive clinical cardiovascular (CV) history or physical findings, any abnormality of the ECG, and fasting blood sugar of 115 mg % (mg/dl) or greater. Thus a CV risk factor index of 5% or greater, positive CV history or physical finding, any abnormality of the ECG, or a fasting blood sugar of 115 mg % (mg/dl) or greater will require further medical testing before clearance is given for this program. Personnel with a CV risk index under 5%, negative CV history and physical examination, no abnormality of the ECG and a fasting blood sugar under 115 mg % (mg/dl) will be cleared to enter this program without further medical attention.

(3) The value obtained for all factors measured will be entered on DA Form 4970 and mailed within 3 days after testing is completed to the Armed Forces Institute of Pathology, ATTN: Department of Cardiovascular Pathology, 14th and Alaska Avenue, NW, Washington, DC 20306. The AFIP will record the data and calculate a supplemental risk index. The risk index and recommendations for subsequent action will be typed in the "For AFIP Use Only" section of the form and returned to the medical examining facility to assist

in decision making. DA Form 4970 with clearance for the Over-40 Fitness Program will be filed in the member's health record. Notification of clearance will then be made by the physical examination section to the individual's personnel records manager, the unit commander and the service member.

(4) When an individual is not cleared on an initial screen further medical or cardiovascular consultation is required. The examining facility will then instruct the service member on the requirement for additional evaluation and assist in scheduling the consultant appointment. If the secondary screen results in clearance of the member, the consultation returned to the medical examining facility will contain that recommendation. The medical examining facility will notify the member's personnel officer that clearance has been given for the member to begin training. If consultation finds clearance cannot be given, the consulting physician will include that recommendation on the consultation form and return it to the medical examining facility. The consulting physician will advise an individualized program and other measures based upon his clinical judgment.

(5) When the secondary screen results in clearance for participation in the program, the medical examining facility will enter the result in the space prepared by AFIP on DA Form 4970 and return the form to AFIP by mail for entry into the computer and subsequent return to the originating facility. The personnel records manager, unit commander, and the individual will be informed of clearance for participation in the program by the physical examination section. When further medical evaluation results in non-clearance, the medical examining facility conducting the examination will again enter the result on DA Form 4970 and return the form to AFIP. After the form is returned by the AFIP, the examining facility will file it in the medical record and accomplish the notification procedure established above.

e. Details for the medical screening examination.

(1) The medical screening examination can be done by the health care professional now performing the periodic medical examinations. All data items, including those now a part of SF Form 88 (Report of Medical Examination) and SF Form 93 (Report of Medical History), will be entered on DA Form 4970 (see fig. 10-4). This form is designed for ADP optical reader processing and must be completed in accordance with the coding instructions on the form. Information must be complete and accurate. Medical examining facilities will not hold completed forms for bulk mailing since this would defeat the purpose of graduated screening and cause undue delays in implementation of the screening as well as clearance of individuals for entry into the program.

f. Instructions for completing DA Form 4970.

(1) Enter the date examination is completed, e.g., 11 Apr 82.

(2) Enter examining facility MTF code, e.g. 1001.

(3) Patient's name, e.g., Doe, John P.

(4) Social security account number without dashes, e.g., 462621593.

(5) The next 7 items are the Framingham Factors and are explained as follows:

(a) Sex: Enter M for male or F for female.

(b) Age: Enter years only as of last birthday, e.g., 40.

(c) Smoking history: Enter average number of cigarettes per day, e.g., 40. If the individual does not smoke cigarettes but smokes a pipe, cigars or chews tobacco, enter 0. (For the purpose of local calculation, less than 10 cigarettes per day average will be considered a negative smoking history.)

(d) Blood Pressure: Blood pressure should be taken in a quiet place after member has relaxed and is sitting comfortably with upper arm at heart level. Enter systolic and diastolic pressures in millimeters of mercury, e.g., 120/80.

(e) Electrocardiogram: A standard 12 lead scalar resting electrocardiogram will be taken and interpreted according to the routine in each examining facility. Left ventricular hypertrophy will be diagnosed only if definite criteria are present. The criteria of Romhilt and Estes or computerized ECG (CAPOC) criteria for definite LVH will obtain. Borderline and/or suggestive findings will not be counted as abnormalities. Entries will be made as follows: NL = Normal; LVH = Left Ventricular Hypertrophy only; ABN = Abnormalities other than LVH; LVH + ABN = LVH plus other abnormalities.

(f) Serum cholesterol: The blood will be drawn in the fasting state at least 12 hours after the last meal which should be of low fat content and analyzed by the method standard for the examining facility. The reported value (mg% or mg/dl) will be entered, e.g., 271.

(g) Fasting blood sugar: The blood will be drawn in the fasting state at least 12 hours after the last meal and analyzed by the method standard for that examining facility. It is suggested that elevated values be followed by telephone locally to insure the individual was fasting and by a repeat determination if necessary. The reported value (mg% or mg/dl) will be entered here, e.g., 109.

(h) Accuracy of laboratory determination is critical to the safety of this program. The cholesterol values in the Coronary Risk Handbook are based on the Abell-Kendall Method. Individual laboratories must use a factor to correct their cholesterol determinations to the Abell-Kendall values. Guidance on value correction methodology for the purpose of standardization of cholesterol and quality assurance of glucose determination will

be obtained from the servicing Regional Medical Center or military reference laboratory (e.g., 10th Med Lab). Blood sugar must be based on true blood glucose level.

(i) Cardiovascular history and physical findings:

1. This item will be marked abnormal if any of the following is found on history or physical examination:

a. Angina pectoris or suspicious chest discomfort.

b. Dyspnea.

c. Syncope.

d. Precordial palpitation.

e. Prior diagnosis of hypertension or treatment of hypertension; history of myocardial infarction.

f. History of a clinical coronary event in a first-order relative (parent or sibling) under age 50.

g. Significant cardiovascular physical finding (e.g., persistent hypertension, pathologic murmur or bruit, cardiomegaly, pathologic heart sound such as third sound, etc.).

h. Any other clinical cardiovascular finding which is significant in the judgment of the examiner.

2. Any abnormality of the electrocardiogram: The Framingham Study identified only left ventricular hypertrophy as an ECG risk factor. For the purpose of this screening examination, any definite abnormality of the electrocardiogram will result in non-clearance and require further medical testing. The electrocardiogram results have already been entered above.

3. Fasting blood sugar: An elevated fasting blood sugar is a risk factor which results in elevation of the risk index. For the purpose of this medical screening examination, a blood sugar of 115 mg % (mg/dl) or greater will be considered abnormal and result in non-clearance and require further medical testing regardless of the risk index. The blood sugar has already been entered above.

(j) The examining facility must provide the complete return address in the space provided on the reverse side of the form.

g. Directions for further medical testing of those not cleared by the initial screening medical examination:

(1) When non-clearance on the initial screen is entered on DA Form 4970 for any reason, the AFIP will return the form to the originating medical examinating facility with a draft consultation sheet (SF 513) accompanying the form to assist the examining facility in the administrative workload. The form will then be forwarded for consultation and further examination by an internal medicine specialist or cardiologist. The member will be notified of time and place for the consultation appointment. Since an exercise tolerance test will customarily be part of this consultation, the member will be directed to report appropriately prepared (e.g., fasting, in comfortable running attire including footgear, and to anticipate a change of clothing before return to duty).

(2) The medical examining facility must provide the consultant with the following:

(a) Member's individual health record.

(b) DA Form 4970.

(c) The X-ray jacket (DA Form 3443), including the chest X-ray made in conjunction with the current periodic examination.

(d) Consultation sheet, SF 513.

(3) The consultation (secondary screen) should include the following:

(a) An independent history and medical examination recorded on SF 513.

(b) A maximum symptom limited exercise tolerance test after appropriate informed consent. The techniques and criteria contained in the following American Heart Association publications should be helpful: Pub #70-041-A, The Exercise Standards Book; Pub #70-008-A, Exercise Testing and Training of Apparently Healthy Individuals; Pub #70-008-B, Exercise Testing and Training of Individuals with Heart Disease or at High Risk for Its Development; and Pub #70-003-A, Coronary Risk Handbook. (These publications have been distributed by The Surgeon General directly to all medical examining facilities.)

(c) Fluoroscopy of the heart for intracardiac calcification, particularly coronary artery calcification if feasible.

(4) If these procedures result in negative or nonremarkable findings, the member should be cleared by the consulting physician. The consultation form will be returned to the originating medical examining facility and filed in the individual's health record. DA Form 4970 will be annotated in the space printed "For AFIP Use Only" and returned to the AFIP where this information will be entered into the computer. The form will then be returned to be filed in the individual's health record.

(5) When one or more of the above procedures are positive or the consulting physician is of the opinion that the member has medical contraindications to routine entry into this program, further testing such as stress thalium testing, coronary angiography, etc., may be in order. In this instance, a medical followup program will likely be indicated and a special individualized exercise program based on the safe exercise level achieved on the exercise tolerance test should be prescribed, if medically feasible. The guidance in the American Heart Association publication mentioned earlier will be helpful in this regard. In this instance, the consultation and DA Form 4970 will also be completed and returned to the originating medical examining facility. The DA Form 4970 will be returned to the AFIP where the data will be entered into the computer. DA Form 4970 will then be returned to the examining facility to be filed along with the consultations in the health record. In each case, the examining facility will notify the member and the personnel records management officer of final clearance or non-clearance for the Over-40 Physical Fitness Program.

h. Notification of results. The medical examining facility is responsible for notifying the member, the member's command and the personnel records manager of the final status and clearance or non-clearance for the program.

i. Point of contact. For questions regarding this program contact COL Julius L. Bedynek, MC, DASG-PSF, Autovon 224-5475/5476.

Page A2-1. Appendix II, Tables of Acceptable Audiometric Hearing Level, is superseded as follows :

APPENDIX II
TABLES OF ACCEPTABLE AUDIOMETRIC HEARING LEVEL

Hearing of all applicants for appointment, enlistment or induction will be tested by audiometers calibrated to the International Standard Organization (ISO 1964) and the American National Standards Institute (ANSI 1969).

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

Table I. Acceptable Audiometric Hearing Level for Appointment, Enlistment and Induction
ISO 1964 - ANSI 1969

Frequency	Both Ears
500 Hz 1000 Hz 2000 Hz 4000 Hz	Audiometer average level of 6 readings (3 per ear) at 500, 1000 and 2000 Hz not more than 30dB, with no individual level greater than 35dB at these frequencies, and level not more than 55dB each ear at 4000Hz; or audiometer level 30dB at 500Hz, 25dB at 1000 and 2000 Hz, and 35dB at 4000Hz in the better ear.

OR

If the average of the 3 speech frequencies is greater than 30dB ISO-ANSI, reevaluate the better ear only in accordance with the following table of acceptability:

Frequency	Better Ear
500 Hz	30 dB
1000 Hz	25 dB
2000 Hz	25 dB
4000 Hz	35 dB

The poorer ear may be deaf.

Table II. Acceptable Audiometric Hearing Level for Army Aviation Including Air Traffic Controllers
ISO 1964 - ANSI 1969 (Unaided Sensitivity)

Frequency		500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz
Classes 1&1A	Each ear	25dB	25dB	25dB	35dB	45dB	45dB
Class 2 (Aviators)	Better ear	25dB	25dB	25dB	35dB	65dB	75dB
	Poorer ear	25dB	35dB	35dB	45dB	65dB	75dB
Class 2 (Air Traffic Controllers)	Each ear	25dB	25dB	25dB	35dB	65dB	75dB
Class 3	Better ear	25dB	25dB	25dB	35dB	65dB	75dB
	Poorer ear	25dB	35dB	35dB	45dB	65dB	75dB

Table III. Acceptable Audiometric Hearing Levels for Admission to US Military Academy, Uniformed Svcs Univ of Health Sciences, ROTC Scholarship Program
ISO 1964 - ANSI 1969 (Unaided Sensitivity)

Frequency	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz
EACH EAR	25dB	25dB	25dB	45dB	45dB	45dB

Pages A8-1 and A8-2, Appendix VIII, Physical Profile Functional Capacity Guide. Column H, Hearing--Ears, is superseded as follows:

Profile serial	H Hearing--Ears
1----------	Audiometer level each ear not more than 25dB at 500, 1000, 2000 Hz with no level greater than 30dB. Not over 45dB at 4000Hz.
2----------	Audiometer average level of 6 readings (3 per ear) at 500, 1000, 2000 Hz not more than 30dB, with no individual level greater than 35dB at these frequencies, and level not more than 55dB at 4000Hz; or audiometer level 30dB at 500Hz, 25dB at 1000 and 2000 Hz, and 35dB at 4000Hz in better ear. (Poorer ear may be deaf.)

Profile serial	H Hearing--Ears
3----------	May have hearing level at 30dB with hearing aid by speech reception score, or acute or chronic ear disease not falling below retention standards (with hearing aid only); may have speech reception threshold level of 30dB with hearing aid set at "comfort level," i.e., adjusted to 50dB HL speech noise, or acute or chronic ear disease not falling below retention standards.
4---------- Factors to be considered	Below standards contained in Chap 3, AR 40-501. Auditory sensitivity and organic disease of the ears.

Pages A9-3, A9-5 and A9-7, Appendix IX, Scope and Recording of Medical Examinations. Items 32, 45, 50, 56 and 69 are superseded as follows:

Item SF88	Types of examinations A	B	Explanatory notes	Model entries
32	X	X	Digital rectal required for all periodic and separation examinations for all members age 40 and over, and on all initial flying and diving duty examinations regardless of age. A definite statement will be made that the examination was performed. Note surgical scars and hemorrhoids in regard to size, number, severity and location. Check fistula, cysts and other abnormalities. Stool occult blood test is required as a part of all digital rectal examinations and results will be entered in item 32.	One small external hemorrhoid, mild. Digital rectal normal. Stool guaiac negative.
45A B C D	X X X X	X X X X	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 and retirement examinations of Active Army members.	
50	X	X	Mammography--After age 50 during periodic examination of Active Army women. White Blood Cell Count--All marine divers.	Identify test(s) and record results.

Item SF88	Types of examinations A	B	Explanatory notes	Model entries
50 (Cont)			Hematocrit (or Hemoglobin) required for all periodic, all flying duty, and all separation examinations. Not required for reserve component personnel, except flying duty. Stool Guaiac--Periodic and separation examinations for all members age 40 and over, and on all initial flying and diving duty examinations regardless of age. Cholesterol and Fasting Blood Glucose)Periodic and separation)examinations for all Act-)ive Army members age 40)and over. Sickle Cell screen required on all flying, HALO, diving duty and ROTC Advance Camp examinations regardless of race. If positive, electrophoresis required. If sickle tests have been done previously, results may be transcribed from official records.	
56	(*)	X	*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6°
69	(*)	(*)	*Only if indicated. Tonometry on all personnel age 40 and over, and on all initial flying duty medical examinations. Tonometry on all ATC personnel in accordance with FAA requirements. 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.

Pages A3-3 and A3-4. Table III and Table IV are rescinded effective 15 April 1983.

Note. Height and weight standards for aviation and diving duties are the height and weight standards prescribed by AR 600-9.

THIS FORM WILL BE READ BY A MACHINE — PLEASE READ AND FOLLOW DIRECTIONS BELOW

MEDICAL SCREENING SUMMARY — OVER-40 PHYSICAL FITNESS PROGRAM

For use of this form, see AR 40-501,102, the proponent agency is the Office of The Surgeon General.

1. DATE OF EXAM (dd mmm yy) 27 FEB 81	2. MTF CODE 1001	3. PATIENT'S NAME (Last, First, MI) Harrison, Benjamin F.	4. SSN 123456789
5. SEX (M=Male, F=Female) M	6. AGE (Current birthday) 42	7. SMOKING HISTORY (Average number of cigarettes per day) 40	8. BLOOD PRESSURE (XXX/XXX mm Hg) 120/100
9. ELECTROCARDIOGRAM (NL=Normal, LVH=Left Ventricular Hypertrophy Only, ABN=Abnormalities other than LVH, LVH+ABN=LVH plus other abnormalities) LVH + ABN			10. SERUM CHOLESTEROL (XXX mg %) 102
11. FASTING BLOOD SUGAR (XXX mg %) 103		12. CARDIOVASCULAR HISTORY AND PHYSICAL (NL=Normal, ABN=Abnormal) ABN	

SAMPLE

FOR AFIP USE ONLY

CODING INSTRUCTIONS

Typewriter setting: 10 Pitch - double space. Use only "OCR-b" typing element, with high yield carbon ribbon. Type only in spaces provided, using specified codes where indicated. After completion, mail to THE ARMED FORCES INSTITUTE OF PATHOLOGY, ATTN: Dept. of Cardiology, 14th & Alaska Ave., N.W., Washington, DC 20306. Type YOUR return address on reverse side of this form in area indicated.

Figure 10-4. Sample DA Form 4970, Medical Screening Summary--Over-40 Physical Fitness Program.

2. Post these changes per DA Pam 310-13.

3. File this interim change in the front of the publication.

(DASG-PSP-O)
By Order of the Secretary of the Army:

E. C. MEYER
General, United States Army
Chief of Staff

Official:

ROBERT M. JOYCE
Major General, United States Army
The Adjutant General

DISTRIBUTION:
Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A, requirements for AR, Medical Service--Applicable to All Army Elements--A.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1983 - 381-661 - 403/3331

5/5 DNT. 106 8 May 1983

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 16 April 1982

Immediate Action
INTERIM CHANGE

AR 40-501
INTERIM CHANGE
NO. I05
Expires 16 April 1983

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

This interim change implements policies and procedures announced by the Army Chief of Staff in Interim Change I01 to AR 600-9, 2 November 1981, requiring all personnel over 40 years of age to be medically screened for participation in the Army's Physical Fitness Training Program; it also modifies portions of Chapter 10, Medical Examinations--Administrative Procedures; Appendix II, Tables of Acceptable Audiometric Hearing Level; Appendix VIII, Physical Profile Functional Capacity Guide; and Appendix IX, Scope and Recording of Medical Examination. This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner superseded by a formal printed change; is being distributed by 1st class mail through the publication pinpoint distribution system to all holders of AR 40-501; is, as an interim measure, issued in other than page-for-page format; and will be included in the next change to AR 40-501. Medical reports generated as a result of the medical screening required by this change are exempt from management information requirements in accordance with paragraph 7-2k, AR 335-15.

Page 10-10, subparagraph 10-23d, is superseded as follows:

d. Reporting of medical conditions.

(1) Reporting of the results of periodic medical examinations pertaining to active Army members age 40 and over will be accomplished as prescribed in paragraph 10-31.

(2) Any change in physical profile or limitations found on periodic medical examination will be reported to the unit commander on DA Form 3349 (Physical Profile Board Proceedings) as prescribed in chapter 9.

(3) Retired personnel will be informed of the results of medical examinations by the examining physician, either verbally or in writing. A copy of the SF 88 may be furnished on request on an individual basis.

Pages 10-10 and 10-11, subparagraph 10-25a is superseded as follows:

a. There is no statutory requirement for members of the active Army (including USMA cadets and members of the USAR and ARNG on active duty or active duty for training) to undergo a medical examination incidental to separation from active Army service. However, except for members retiring after more than 20 years of active service, it is Army policy to accomplish a medical examination if the member requests it.

The Army Library (ANRAL)
ATTN: Military Documents
Room 1A518, Pentagon
Washington, D.C. 20310

(1) Active Army members retiring after more than 20 years active duty are required to undergo a medical examination prior to retirement. Results of that examination will be reported as indicated in paragraph 10-31.

(2) The following schedule of separation medical examinations is established:

	Required	Not required	Can be requested by member (in writing)
Retirement after 20 or more years of active duty.	X*		
Retirement from active service for physical disability, permanent or temporary, regardless of length of service.	X*		
Expiration of term of active service (separation or discharge, less that 20 years of service).		X	X
Upon review of Health Record, evaluating physician or physician assistant (PA)** at servicing MTF determines that, because of medical care received during active service, medical examination will serve best interests of member and Government; e.g., hospitalization for other than diagnostic purposes within 1 year of anticipated separation date.	X*		
Individual is member of Army National Guard on active duty or active duty for training in excess of 30 days.		X	X
Individual is member of Army National Guard and has been called into Federal service (10USC3502).	X*		
Deserters who return to military control and are being processed for judicial or administrative discharge except discharge under chapter 10 or section V, chapter 14 of AR 635-200.	X*		
Prisoners of war, including internees and repatriates, undergoing medical care, convalescence or rehabilitation, who are being separated.	X*		
Officers, WOs and enlisted members previously determined eligible for separation or retirement for physical disability but continued on	X (Plus MEB and PEB)		

*See footnotes at end of table.

active duty after complete physical disability processing (chap. 6, AR 635-40 and predecessor regulations).			
Officers, WOs and enlisted members previously processed for physical disability (AR 635-40) and found fit for duty with one or more numerical permanent designators "4" in physical profile serial.	X*		
All officers, WOs and enlisted members with one or more temporary numerical designators "4" in physical profile serial.	X*		
Officers and WOs being processed for separation under provisions of sections XV, XIX, XXVIIIof chapter 3, and section IV of chapter 5, AR 635-100; chapters 4, 5, 7, 10, 12, 16, AR 635-120.	X*		
Officers and WOs separated under provisions of AR 635-100 and AR 635-120 other than listed.		X	X
Enlisted members being processed for separation under provisions of paragraphs 5-3, 5-6 and 5-14 of chapter 5, section III of chapter 8, chapter 9, paragraph 14-23, section IV of chapter 14, AR 635-200.	X		
Enlisted members being processed for separation under provisions of chapter 13, AR 635-200 (both mental evaluation and medical examination required).	X		
Enlisted members being processed for separation under provisions of chapter 10, and section V of chapter 14, AR 635-200. (Mental evaluation only is required. Medical examination may be requested by member in writing and, if so requested, should be accomplished expeditiously without regard to time constraints otherwise applicable in this paragraph to voluntary examination.)	X		
Discharge in absentia (officers and enlisted members):			

*See footnotes at end of table.

Civil confinement	X	
When BCD or DD is upheld by appellate review and individual is on excess leave.	X	
Deserters who do not return to military control.	X	
Enlisted members being processed for separation under all other provisions of AR 635-200 not listed above.	X	X

* Examination will be accomplished not earlier than 4 months, nor later than 1 month prior to scheduled date of retirement discharge, relief from active duty or active duty for training.

** PAs may review health records of officers, WOs and enlisted members upon expiration of term of service (separation or discharge) if such authority has been designated to them by the supervising physician and approved by the MTF cdr, or unit staff surgeon.

Page 10-18, paragraph 10-31 is added as follows:

10-31. Medical Evaluation -- Army Physical Fitness and Weight Control Program for Active Members Age 40 and Over.

a. Criteria. The routine medical examinations will be utilized as a vehicle for accomplishing the initial cardiovascular screening for personnel 40 years of age and over prior to entry into the Army Over-40 Physical Fitness Program. No personnel age 40 and over shall enter the training program or be tested prior to cardiovascular screening. The procedures to be followed in screening for coronary heart disease will result in calculation of an overall risk index. This risk index will be based on tables derived from the Framingham Study on heart disease which combines input from seven risk factors to include age, sex, smoking habit, systolic blood pressure, resting ECG for left ventricular hypertrophy, carbohydrate intolerance, and cholesterol.

(1) Additional secondary screening will be required for those who:

(a) Possess a relatively high risk index of 5% or greater.

(b) Have a clinical cardiovascular finding:

1 Have a history of chest discomfort, dyspnea, syncope, palpitation, hypertension, or drug treatment of hypertension.

2 Have a cardiovascular abnormality on physical examination such as cardiomegaly, murmur, etc.

(c) Have any abnormality on ECG.

(d) Have a fasting blood sugar of 115 mg % (mg/dl) or over (carbohydrate intolerance).

(2) Personnel who have none of the above factors may be cleared to enter directly into this program. Those who require additional screening may be subsequently cleared and enter the program or may require an individualized program prescribed by the consulting physician.

(3) Personnel 40 years of age or over who are already in training may maintain their current level of exercise activity until undergoing medical screening and, if cleared, can advance to greater levels of exercise activity. Testing may be accomplished 6 months after cardiovascular screening results in clearance for participation in the program.

b. Implementation. Implementation of the screening to reach all personnel already age 40 or over will require a special schedule for medical examination. All such members will receive a complete medical examination during the month of birth at age 40, 42, 44, etc. This will allow all such members to be screened within the next 2 years. Personnel will be identified for the periodic medical examination and screening for this program and notified through procedures prescribed in DA Pamphlet 600-8. The cardiovascular screen will thereafter be administered to all members age 40 or over at the time of each periodic medical examination at 5-year intervals (see para 10-23c) and during retirement medical examination. The retirement medical examination for those over 40 will henceforth be mandatory (see para 10-25a). Members currently under age 40 will have a medical examination including cardiovascular screening upon attaining age 40 even if involved in a training program at the time. The cardiovascular screen will be a regular part of every medical examination after age 40.

(1) Commanders at all levels will be responsible for insuring that all personnel over 40 years of age are screened and subsequently participate in the Physical Fitness Training or a modified program as prescribed by consulting physicians.

(2) Commanders at Medical Centers and MEDDACs will be responsible for implementing procedures established in this regulation. This will require involvement of the Chiefs of Ambulatory Care and Departments of Medicine in scheduling and processing examinations in a timely manner. Local commanders must be briefed on the capabilities of the medical facility and the time frame necessary for completion of the screening for all personnel. A continued review will be necessary to insure accuracy of data collected and full participation by all personnel.

c. Data Processing. A central registry for monitoring, evaluating, and

record keeping at the Armed Forces Institute of Pathology (AFIP) will be part of the program. Close coordination and feedback between personnel records offices and medical examining facilities will be necessary to insure success of this critical element of the program.

NOTE. Initial distribution of DA Form 4970 will be made under separate cover.

(1) The DA Form 4970 (Medical Screening Summary--Over-40 Physical Fitness Program) has been designed as a single form to accomplish all record keeping and data transmittal in this program. (See fig. 10-4 for sample form.) Data obtained in the initial screen will be typed on the front of this form and forwarded to the AFIP where a risk index will be calculated to assist the examining facility in decisionmaking. Calculation results and recommendations will be printed in the for AFIP only section and returned to the examining facility for processing. The Medical Examining Section will be responsible for processing the examination results and DA Form 4970. A suspense file will be necessary to verify return receipt of all forms which have been forwarded to AFIP. Each time the examination results are forwarded to the AFIP, they will be processed and the form expeditiously returned to the original examining facility. For those personnel who are not cleared, a draft SF 513 (Medical Record--Consultation Sheet) will be prepared and returned with DA Form 4970 to help accomplish a secondary screen. When the secondary screen is completed the results will be entered in a space prepared by the computer in the AFIP only section. The original form will be returned to AFIP. The AFIP will return the form to the examining station for filing as a permanent part of the individual health record when all screening has been completed. A new form should never be initiated at any point in the screening process unless the original has been lost.

(2) All required information will be recorded on the original copy of DA Form 4970 and forwarded to the AFIP for record keeping, regardless, if local physicians determine eligibility for training and testing. The original copy will be processed by ADP optical readers which will be utilized for timely processing and recording of all data. The process for decisionmaking is outlined within this section. It is sufficiently straightforward to permit local determination with assistance from the references cited at paragraph g(3)(b) below.

(3) The cardiovascular screening program is designed for integration with the periodic medical examination. Mass screening will not be done because the quality of the screening examination will suffer and mass screening will overload the medical system. Local commanders will have latitude in increasing the number of physicals done in the examining station, where feasible, and thus accelerate the completion of the screening. Commanders are reminded that medical examination and followup screening specialty clinics cannot handle excessive screening loads while continuing to support the medical care mission.

d. Screening instructions.

(1) The cardiovascular screen will be based on the 7 risk factors taken from The Framingham Study. Virtually all of these risk factors are now being measured in the routine periodic medical examination. The 7 risk factors will be used to calculate a risk factor index as outlined by the American Heart Association Publication 70-003-A Coronary Risk Handbook. A risk factor index of 5% or greater likelihood of developing coronary heart disease in 6 years will require the member to undergo further medical testing within regular medical channels before clearance is given for participation in the program.

(2) Three additional related factors will be addressed at the time of the initial examination: positive clinical cardiovascular (CV) history or physical findings, any abnormality of the ECG, and fasting blood sugar of 115 mg % (mg/dl) or greater. Thus a CV risk factor index of 5% or greater, positive CV history or physical finding, any abnormality of the ECG, or a fasting blood sugar of 115 mg % (mg/dl) or greater will require further medical testing before clearance is given for this program. Personnel with a CV risk index under 5%, negative CV history and physical examination, no abnormality of the ECG and a fasting blood sugar under 115 mg % (mg/dl) will be cleared to enter this program without further medical attention.

(3) The value obtained for all factors measured will be entered on DA Form 4970 and mailed within 3 days after testing is completed to the Armed Forces Institute of Pathology, ATTN: Department of Cardiovascular Pathology, 14th and Alaska Avenue, NW, Washington, DC 20306. The AFIP will record the data and calculate a supplemental risk index. The risk index and recommendations for subsequent action will be typed in the AFIP only section of the form and returned to the medical examining facility to assist in decisionmaking. DA Form 4970 with clearance for the Over-40 Fitness Program will be filed in the member's health record. Notification of clearance will then be made by the physical examination section to the individual's personnel records manager, the unit commander and the service member.

(4) When an individual is not cleared on an initial screen, further medical or cardiovascular consultation is required. The examining facility will then instruct the service member on the requirement for additional evaluation and assist in scheduling the consultant appointment. If the secondary screen results in clearance of the member, the consultation returned to the medical examining facility will contain that recommendation. The medical examining facility will notify the member's personnel officer that clearance has been given for the member to begin training. If consultation finds clearance cannot be given, the consulting physician will include that recommendation on the consult form and return it to the medical examining facility. The consulting physician will advise an individualized exercise program and other measures based upon his clinical judgment.

(5) When the secondary screen results in clearance for participation in

the program, the medical examining facility will enter the result in the space prepared by AFIP on DA Form 4970 and return the form to AFIP by mail for entry into the computer and subsequent return to the originating facility. The personnel records manager, unit commander, and the individual will be informed of clearance for participation in the program by the physical examination section. When further medical evaluation results in non-clearance, the medical examining facility conducting the examination will again enter the result on DA Form 4970 and return the form to AFIP. After the form is returned by the AFIP, the examining facility will file it in the medical record and accomplish the notification procedure established above.

e. Details for the medical screening examination.

(1) The medical screening examination can be done by the health care professional now performing the periodic medical examinations. All data items, including those not now a part of SF Forms 88 (Report of Medical Examination) and 93 (Report of Medical History), will be entered on DA Form 4970 (see fig. 10-4). This form is designed for ADP optical reader processing and must be completed in accordance with the coding instructions on the form. Information must be complete and accurate. Medical examining facilities will not hold completed forms for bulk mailing since this would defeat the purpose of graduated screening and cause undue delays in implementation of the screening as well as clearance of individuals for entry into the program.

f. Instructions for completing DA Form 4970.

(1) Enter the date examination is completed; e.g., 11 Feb 81.

(2) Enter examining facility MTF code; e.g., 1001.

(3) Patients name; e.g., Doe, John P.

(4) Social security account number without dashes; e.g., 462621593.

(5) The next seven items are the Framingham Factors and are explained as follows:

(a) Sex: Enter M for male or F for female.

(b) Age: Enter years only as of last birthday; e.g., 40.

(c) Smoking history: Enter average number of cigarettes per day; e.g., 40. If the individual does not smoke cigarettes or smokes a pipe, cigars or chews tobacco enter 0. (For the purpose of local calculation, less than 10 cigarettes per day average will be considered a negative smoking history.)

(d) Blood Pressure: Blood pressure should be taken in a quiet place after member has relaxed and is sitting comfortably with upper arm at heart level. Enter systolic and diastolic pressures in millimeters of mercury; e.g., 120/80.

(e) Electrocardiogram: A standard 12 lead scalar resting electrocardiogram will be taken and interpreted according to the routine in each examining facility. Left ventricular hypertrophy will be diagnosed only if definite criteria are present. The criteria of Romhilt and Estes or computerized ECG (CAPOC) criteria for definite LVH will obtain. Borderline and/or suggestive findings will not be counted as abnormalities. Entries will be made as follows: NL= Normal; LVH= Left Ventricular Hypertrophy only; ABN= Abnormalities other than LVH; LVH + ABN= LVH plus other abnormalities.

(f) Serum cholesterol: The blood will be drawn in the fasting state at least 12 hours after the last meal which should be of lowfat content and analyzed by the method standard for that examining facility. The reported value (mg% or mg/dl) will be entered; e.g., 271.

(g) Fasting blood sugar: The blood will be drawn in the fasting state at least 12 hours after the last meal and analyzed by the method standard for that examining facility. It is suggested that elevated values be followed up by telephone locally to insure the individual was fasting and by a repeat determination if necessary. The reported value (mg % or mg/dl) will be entered here; e.g., 109.

(h) Accuracy of laboratory determinations is critical to the safety of this program. The cholesterol values in the Coronary Risk Handbook are based on the Abell-Kendall Method. Individual laboratories must use a factor to correct their cholesterol determinations to the Abell-Kendall values. Guidance on value correction methodology for the purpose of standardization of cholesterol and quality assurance of glucose determinations will be obtained from the servicing Regional Medical Center or military reference laboratory (e.g., 10th Med Lab). Blood sugar must be based on true blood glucose level.

(i) Cardiovascular history and physical findings:

1 This item will be marked abnormal if any of the following is found on history or physical examination:

a Angina pectoris or suspicious chest discomfort.

b Dyspnea.

c Syncope.

d Precordial palpitation.

e Prior diagnosis of hypertension or treatment of hypertension; history of myocardial infarction.

f Significant cardiovascular physical finding (e.g., pathologic murmur or bruit, cardiomegaly, pathologic heart sound such as third sound, etc.).

g Any other clinical cardiovascular finding which is significant in the judgement of the examiner.

2 Any abnormality of the electrocardiogram: The Framingham Study identified only left ventricular hypertrophy as an ECG risk factor. For the purpose of this screening examination, any definite abnormality of the electrocardiogram will result in non-clearance and require further medical testing. The electrocardiogram results have already been entered above.

3 Fasting blood sugar: An elevated fasting blood sugar is a risk factor which results in elevation of the risk index. For the purpose of this medical screening examination, a blood sugar of 115 mg % (mg/dl) or greater will be considered abnormal and result in non-clearance and require further medical testing regardless of the risk index. The blood sugar has already been entered above.

(j) The examining facility must provide the complete return address in the space provided on the reverse side of the form.

g. Directions for further medical testing of those not cleared by the initial screening medical examination:

(1) When non-clearance on the initial screen is entered on DA Form 4970 for any reason, the AFIP will return the form to the originating medical examining facility with a draft consultation sheet (SF 513) accompanying the form to assist the examining facility in the administrative workload. The form will then be forwarded for consultation and further examination by an internal medicine specialist or cardiologist. The member will be notified of time and place for the consultation appointment. Since an exercise tolerance test will customarily be part of this consultation, the member will be directed to report appropriately prepared (e.g., fasting, in comfortable running attire including foot gear, and to anticipate a change of clothing before return to duty).

(2) The medical examining facility must provide the consultant with the following:

(a) Member's individual health record.

(b) DA Form 4970.

(c) The X-ray jacket including the chest X-ray made in conjunction with the current periodic examination.

(d) Consultation sheet, SF 513.

(3) The consultation (secondary screen) should include the following:

(a) An independent history and medical examination recorded on SF 513.

(b) A maximum symptom limited exercise tolerance test after appropriate informed consent. The techniques and criteria contained in the following American Heart Association publications should be helpful: Pub #70-041-A, The Exercise Standards Book; Pub #70-008-A, Exercise Testing and Training of Apparently Healthy Individuals; Pub #70-008-B, Exercise Testing and Training of Individuals with Heart Disease or at High Risk for its Development; and Pub #70-003-A, Coronary Risk Handbook. (These publications have been distributed to all medical examining facilities.)

(c) Fluoroscopy of the heart for intracardiac calcification, particularly coronary artery calcification if feasible.

(4) If these procedures result in negative or nonremarkable findings, the member should be cleared by the consulting physician. The consultation form will be returned to the originating medical examining facility and filed in the individual's health record. DA Form 4970 will be annotated in the space printed in the AFIP only section and returned to the AFIP where this information will be entered into the computer. The form will then be returned to be filed in the individual's health record.

(5) When one or more of the above procedures are positive or the consulting physician is of the opinion that the member has medical contraindications to routine entry into this program, further testing such as stress thalium testing, coronary angiography, etc., may be in order. In this instance, a medical follow-up program will likely be indicated and a special individualized exercise program based on the safe exercise level achieved on the exercise tolerance test should be prescribed, if medically feasible. The guidance in the American Heart Association publications mentioned earlier will be helpful in this regard. In this instance, the consultation and DA Form 4970 will also be completed and returned to the originating medical examining facility. The DA Form 4970 will be returned to AFIP where the data will be entered into the computer. DA Form 4970 will then be returned to the examining facility to be filed along with the consultations in the health record. In each case the examining facility will notify the personnel records management officer of final clearance or non-clearance for the Over-40 Physical Fitness Program.

h. Notification of results. The medical examining facility is responsible

for notifying the member's command and the personnel records manager of the final status and clearance or non-clearance for the program.

i. Point of contact. For questions regarding this program contact COL Bedynek or MAJ Broadway, DASG-PSC, Autovon 227-8394.

Page A2-1, Appendix II, Tables of Acceptable Audiometric Hearing Level. Table III, Acceptable Audiometric Hearing Level for Admission to the US Military Academy, (ANSI 1969) (Unaided Acuity), is superseded as follows:

Table III. Acceptable Audiometric Hearing Level for Admission to US Military Academy, ISO--1964 (ANSI 1969) (Unaided Acuity)

Cycles per Second (Hz)	Each ear
250	No requirement
500	30 dB
1000	25 dB
2000	25 dB
3000	No requirement
4000	45 dB
6000	No requirement
8000	No requirement

Pages A8-1 and A8-2. Appendix VIII, Physical Profile Functional Capacity Guide. Column H, Hearing--Ears, is superseded as follows:

Profile serial	H Hearing--Ears
1----------	Audiometer average level each ear not more than 27 dB at 500, 1000, 2000 Hz; not over 45 dB at 4000 Hz.
2----------	Audiometer average level not more than 31 dB at 500, 1000, 2000 Hz and 55dB at 4000 Hz in both ears, or 30 dB at 500 Hz and 25 dB at 1000 and 2000 Hz and 35 dB at 4000 Hz in the better ear.
3----------	May have hearing level at 30 dB with hearing aid by speech reception score, or acute or chronic ear disease not falling below retention standards (with hearing aid only); may have

	speech reception threshold level of 30 dB with hearing aid set at "comfort level" (i.e., adjusted to 50 dB HL speech noise), or acute or chronic ear disease not falling below retention standards.
4----------	Below retention standards. Auditory acuity, and organic disease of the ears.

NOTE: The odd numbers 27 dB and 31 dB reflect averaging of ASA to ISO.

Pages A9-3, A9-5 and A9-7. Appexdix IX, Scope and Recording of Medical Examinations.

Items 32, 45, 50, 56 and 69 are superseded as follows:

Item SF 88	Types of examinations A	Types of examinations B	Explanatory notes	Model entries
32	X	X	Digital rectal required for all periodic examinations of Active Army members regardless of age. A definite statement will be made that 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.
45A	X	X	Identify tests used and record results.	
B	X	X	Items A and D not routinely required for	
C	X	X	Type A medical examinations accomplished	
D	X	X	for initial entrance or for routine separation. Must be accomplished for all Type B examinations and for periodic and retirement examinations of Active Army members.	
50	X	X	Mammography--After age 50 during periodic examination of Active Army women.	Identify test(s) and record results.
	X	X	White Blood Cell Count--All marine divers	
	X	X	Hematocrit--Required for periodic and separation examinations for Active Army members.	
	X	X	Stool Guaiac--Same as Hematocrit above.	
	X	X	Cholesterol--Same as Hematocrit above.	
	X	X	Triglycerides--Same as Hematocrit above.	
	X	X	Fasting Blood Sugar--Same as Hematocrit above.	
56	(*)	X	*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6°
69	(*)	(*)	*Only if indicated.	
			Tonometry--Required for periodic examinations of Active Army members age 40 and over.	
			Tonometry--Required for all ATC personnel regardless of age.	
			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.

THIS FORM WILL BE READ BY A MACHINE — PLEASE READ AND FOLLOW DIRECTIONS BELOW

MEDICAL SCREENING SUMMARY — OVER-40 PHYSICAL FITNESS PROGRAM

For use of this form, see AR 40-501,102, the proponent agency is the Office of The Surgeon General.

1. DATE OF EXAM (dd mmm yy) 27 FEB 81	2. MTF CODE 1001	3. PATIENT'S NAME (Last, First, MI) Harrison, Benjamin F.	4. SSN 123456789
5. SEX (M=Male, F=Female) M	6. AGE (Current Birthday) 42	7. SMOKING HISTORY (Average number cigarettes per day) 40	8. BLOOD PRESSURE (XXX/XXX mm Hg) 120/100
9. ELECTROCARDIOGRAM (NL=Normal, LVH=Left Ventricular Hypertrophy Only, ABN=Abnormalities other than LVH, LVH + ABN=LVH plus other abnormalities) LVH + ABN			10. SERUM CHOLESTEROL (XXX mg %) 102
11. FASTING BLOOD SUGAR (XXX mg %) 103		12. CARDIOVASCULAR HISTORY AND PHYSICAL (NL=Normal, ABN=Abnormal) ABN	

FOR AFIP USE ONLY

CODING INSTRUCTIONS

Typewriter setting: 10 Pitch - double space. Use only "OCR-b" typing element, with high yield carbon ribbon. Type only in spaces provided, using specified codes where indicated. After completion, mail to THE ARMED FORCES INSTITUTE OF PATHOLOGY, ATTN: Dept. of Cardiology, 14th & Alaska Ave., N.W., Washington, DC 20306. Type YOUR return address on reverse side of this form in area indicated.

Figure 10-4. Sample DA Form 4970, Medical Screening Summary--Over-40 Physical Fitness Program.

(DASG-PSP-O)
By Order of the Secretary of the Army:

E. C. MEYER
General, United States Army
Chief of Staff

Official:

ROBERT M. JOYCE
Brigadier General, United States Army
The Adjutant General

DISTRIBUTION:
Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A, requirements for AR, Medical Service--Applicable to all Army Elements--A.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1982 - 361-661 - 403/2495

Reference

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 5 May 1981

Immediate Action
INTERIM CHANGE

AR 40-501
INTERIM CHANGE
NO. I03
Expires 5 May 1982

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

This interim change corrects information contained in item 50, Appendix IX, Scope and Recording of Medical Examination, AR 40-501. This interim change expires 1 year from date of publication and will be destroyed at that time unless sooner superseded by a formal printed change; is being distributed by first class mail through the publication pinpoint distribution system to all holders of AR 40-501; is, as an interim measure, issued in other than page-for-page format; and will be included in the next change to AR 40-501.

Page A9-5, Appendix IX, Scope and Recording of Medical Examinations. Item 50 is superseded as follows:

Item SF 88	Types of examinations A	B	Explanatory notes	Model entries
50	X	X	Mammography--After age 50 during periodic examination of Active Army women	Identify test(s) & record results
	X	X	White Blood Cell Count--All marine divers.	
	X	X	Hematocrit--Required for periodic and separation examinations for Active Army members regardless of age.	
	X	X	Stool Guaiac)Periodic and separa-	
	X	X	Cholesterol)tion examinations for,	
	X	X	Triglycerides)all Active Army	
	X	X	Fasting Blood Sugar)members age 40 and over.	

(DASG-PSP-O)
By Order of the Secretary of the Army:

E. C. MEYER
General, United States Army
Chief of Staff

Official:

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

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☆U.S. GOVERNMENT PRINTING OFFICE: 1981—341-661:1490

Reference

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 25 August 1981

Immediate Action
INTERIM CHANGE

AR 40-501
INTERIM CHANGE
NO. 104
Expires 25 August 1982

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

This interim change adds a new subparagraph regarding frequency of medical examinations for General Officers. This interim change expires 1 year from date of publication and will be destroyed at that time unless sooner superseded by a formal printed change; is being distributed by first class mail through the publication pinpoint distribution system to all holders of AR 40-501; is, as an interim measure, issued in other than page-for-page format; and will be included in the next change to AR 40-501.

Page 10-9, paragraph 10-23c. Frequency. A new subparagraph (1) is added as follows:

(1) General Officers.

(a) All General Officers on active duty will undergo an annual medical examination within 3 calendar months before the end of the birthday month (Type B for those who are aviators, Type A for all others). In addition to the scope of the examination prescribed by appendix IX, the cardiovascular screening prescribed by paragraph 10-31 will be accomplished. Examinations will be scheduled on an individual appointment basis and accomplished on an outpatient or inpatient basis, depending upon the professional judgment of the examining physician(s). Additional tests/diagnostic procedures in excess of the prescribed scope of the examination will be accomplished when, in the opinion of the examining physician(s), such procedures are indicated.

(b) The annual dental examination prescribed by AR 40-3 will, as far as practicable, also be accomplished.

(c) Immunization records will be reviewed and required immunizations will be administered (AR 40-562).

Pages 10-9 and 10-10, subparagraphs 10-23c(1) through (10). Renumber to read subparagraphs 10-23c(2) through (11).

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(DASG-PSP-O)
By Order of the Secretary of the Army:

E. C. MEYER
General, United States Army
Chief of Staff

Official:

ROBERT M. JOYCE
Brigadier General, United States Army
The Adjutant General

DISTRIBUTION:
Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A, requirements for AR, Medical Service--Applicable to all Army Elements--A.

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HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 24 March 1981

AR 40-501
INTERIM CHANGE
NO. I02
Expires 24 March 1982

Expired

Immediate Action
INTERIM CHANGE

MEDICAL SERVICES
STANDARDS OF MEDICAL FITNESS

This interim change implements policies and procedures announced by the Army Chief of Staff in Interim Change I01 to AR 600-9, 15 October 1980, requiring all personnel over 40 years of age to be medically screened for participation in the Army's Physical Fitness Training Program; it also modifies portions of Chapter 10, Medical Examinations--Administrative Procedures; Appendix II, Tables of Acceptable Audiometric Hearing Level; Appendix VIII, Physical Profile Functional Capacity Guide; and Appendix IX, Scope and Recording of Medical Examination. This interim change expires 1 year from date of publication and will be destroyed at that time unless sooner superseded by a formal printed change; is being distributed by 1st class mail through the publication pinpoint distribution system to all holders of AR 40-501; is, as an interim measure, issued in other than page-for-page format; and will be included in the next change to AR 40-501. Medical reports generated as a result of the medical screening required by this change are exempt from management information requirements in accordance with paragraph 7-2k, AR 335-15.

Page 10-10, subparagraph 10-23d, is superseded as follows:

d. Reporting of medical conditions.

(1) Reporting of the results of periodic medical examinations pertaining to active Army members age 40 and over will be accomplished as prescribed in paragraph 10-31.

(2) Any change in physical profile or limitations found on periodic medical examination will be reported to the unit commander on DA Form 3349 (Physical Profile Board Proceedings) as prescribed in chapter 9.

(3) Retired personnel will be informed of the results of medical examinations by the examining physician, either verbally or in writing. A copy of the SF 88 may be furnished on request on an individual basis.

Pages 10-10 and 10-11, subparagraph 10-25a is superseded as follows:

a. There is no statutory requirement for members of the active Army (including USMA cadets and members of the USAR and ARNG on active duty or active duty for training) to undergo a medical examination incidental to separation from active Army service. However, except for members retiring after more than 20 years of active service, it is Army policy to accomplish a medical examination if the member requests it.

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(1) Active Army members retiring after more than 20 years active duty are required to undergo a medical examination prior to retirement. Results of that examination will be reported as indicated in paragraph 10-31.

(2) The following schedule of separation medical examinations is established:

	Required	Not required	Can be requested by member (in writing)
Retirement after 20 or more years of active duty.	X*		
Retirement from active service for physical disability, permanent or temporary, regardless of length of service.	X*		
Expiration of term of active service (separation or discharge, less that 20 years of service).		X	X
Upon review of Health Record, evaluating physician or physician assistant (PA)** at servicing MTF determines that, because of medical care received during active service, medical examination will serve best interests of member and Government; e.g., hospitalization for other than diagnostic purposes within 1 year of anticipated separation date.	X*		
Individual is member of Army National Guard on active duty or active duty for training in excess of 30 days.		X	X
Individual is member of Army National Guard and has been called into Federal service (10USC3502).	X*		
Deserters who return to military control and are being processed for judicial or administrative discharge except discharge under chapter 10 or section V, chapter 14 of AR 635-200.	X*		
Prisoners of war, including internees and repatriates, undergoing medical care, convalescence or rehabilitation, who are being separated.	X*		
Officers, WOs and enlisted members previously determined eligible for separation or retirement for physical disability but continued on	X (Plus MEB and PEB)		

*See footnotes at end of table.

active duty after complete physical disability processing (chap. 6, AR 635-40 and predecessor regulations).			
Officers, WOs and enlisted members previously processed for physical disability (AR 635-40) and found fit for duty with one or more numerical permanent designators "4" in physical profile serial.	X*		
All officers, WOs and enlisted members with one or more temporary numerical designators "4" in physical profile serial.	X*		
Officers and WOs being processed for separation under provisions of sections XV, XIX, XXVIIIof chapter 3, and section IV of chapter 5, AR 635-100; chapters 4, 5, 7, 10, 12, 16, AR 635-120.	X*		
Officers and WOs separated under provisions of AR 635-100 and AR 635-120 other than listed.		X	X
Enlisted members being processed for separation under provisions of paragraphs 5-3, 5-6 and 5-14 of chapter 5, section III of chapter 8, chapter 9, paragraph 14-23, section IV of chapter 14, AR 635-200.	X		
Enlisted members being processed for separation under provisions of chapter 13, AR 635-200 (both mental evaluation and medical examination required).	X		
Enlisted members being processed for separation under provisions of chapter 10, and section V of chapter 14, AR 635-200. (Mental evaluation only is required. Medical examination may be requested by member in writing and, if so requested, should be accomplished expeditiously without regard to time constraints otherwise applicable in this paragraph to voluntary examination.)	X		
Discharge in absentia (officers and enlisted members):			

*See footnotes at end of table.

Civil confinement	X	
When BCD or DD is upheld by appellate review and individual is on excess leave.	X	
Deserters who do not return to military control.	X	
Enlisted members being processed for separation under all other provisions of AR 635-200 not listed above.	X	X

* Examination will be accomplished not earlier than 4 months, nor later than 1 month prior to scheduled date of retirement discharge, relief from active duty or active duty for training.

** PAs may review health records of officers, WOs and enlisted members upon expiration of term of service (separation or discharge) if such authority has been designated to them by the supervising physician and approved by the MTF cdr, or unit staff surgeon.

Page 10-18, paragraph 10-31 is added as follows:

10-31. Medical Evaluation -- Army Physical Fitness and Weight Control Program for Active Members Age 40 and Over.

a. Criteria. The routine medical examinations will be utilized as a vehicle for accomplishing the initial cardiovascular screening for personnel 40 years of age and over prior to entry into the Army Over-40 Physical Fitness Program. No personnel age 40 and over shall enter the training program or be tested prior to cardiovascular screening. The procedures to be followed in screening for coronary heart disease will result in calculation of an overall risk index. This risk index will be based on tables derived from the Framingham Study on heart disease which combines input from seven risk factors to include age, sex, smoking habit, systolic blood pressure, resting ECG for left ventricular hypertrophy, carbohydrate intolerance, and cholesterol.

(1) Additional secondary screening will be required for those who:

(a) Possess a relatively high risk index of 5% or greater.

(b) Have a clinical cardiovascular finding:

1 Have a history of chest discomfort, dyspnea, syncope, palpitation, hypertension, or drug treatment of hypertension.

2 Have a cardiovascular abnormality on physical examination such as cardiomegaly, murmur, etc.

(c) Have any abnormality on ECG.

(d) Have a fasting blood sugar of 115 mg % (mg/dl) or over (carbohydrate intolerance).

(2) Personnel who have none of the above factors may be cleared to enter directly into this program. Those who require additional screening may be subsequently cleared and enter the program or may require an individualized program prescribed by the consulting physician.

(3) Personnel 40 years of age or over who are already in training may maintain their current level of exercise activity until undergoing medical screening and, if cleared, can advance to greater levels of exercise activity. Testing may be accomplished 6 months after cardiovascular screening results in clearance for participation in the program.

b. Implementation. Implementation of the screening to reach all personnel already age 40 or over will require a special schedule for medical examination. All such members will receive a complete medical examination during the month of birth at age 40, 42, 44, etc. This will allow all such members to be screened within the next 2 years. Personnel will be identified for the periodic medical examination and screening for this program and notified through procedures prescribed in DA Pamphlet 600-8. The cardiovascular screen will thereafter be administered to all members age 40 or over at the time of each periodic medical examination at 5-year intervals (see para 10-23c) and during retirement medical examination. The retirement medical examination for those over 40 will henceforth be mandatory (see para 10-25a). Members currently under age 40 will have a medical examination including cardiovascular screening upon attaining age 40 even if involved in a training program at the time. The cardiovascular screen will be a regular part of every medical examination after age 40.

(1) Commanders at all levels will be responsible for insuring that all personnel over 40 years of age are screened and subsequently participate in the Physical Fitness Training or a modified program as prescribed by consulting physicians.

(2) Commanders at Medical Centers and MEDDACs will be responsible for implementing procedures established in this regulation. This will require involvement of the Chiefs of Ambulatory Care and Departments of Medicine in scheduling and processing examinations in a timely manner. Local commanders must be briefed on the capabilities of the medical facility and the time frame necessary for completion of the screening for all personnel. A continued review will be necessary to insure accuracy of data collected and full participation by all personnel.

c. Data Processing. A central registry for monitoring, evaluating, and

record keeping at the Armed Forces Institute of Pathology (AFIP) will be part of the program. Close coordination and feedback between personnel records offices and medical examining facilities will be necessary to insure success of this critical element of the program.

NOTE. Initial distribution of DA Form 4970 will be made under separate cover.

(1) The DA Form 4970 (Medical Screening Summary--Over-40 Physical Fitness Program) has been designed as a single form to accomplish all record keeping and data transmittal in this program. (See fig. 10-4 for sample form.) Data obtained in the initial screen will be typed on the front of this form and forwarded to the AFIP where a risk index will be calculated to assist the examining facility in decisionmaking. Calculation results and recommendations will be printed in the for AFIP only section and returned to the examining facility for processing. The Medical Examining Section will be responsible for processing the examination results and DA Form 4970. A suspense file will be necessary to verify return receipt of all forms which have been forwarded to AFIP. Each time the examination results are forwarded to the AFIP, they will be processed and the form expeditiously returned to the original examining facility. For those personnel who are not cleared, a draft SF 513 (Medical Record--Consultation Sheet) will be prepared and returned with DA Form 4970 to help accomplish a secondary screen. When the secondary screen is completed the results will be entered in a space prepared by the computer in the AFIP only section. The original form will be returned to AFIP. The AFIP will return the form to the examining station for filing as a permanent part of the individual health record when all screening has been completed. A new form should never be initiated at any point in the screening process unless the original has been lost.

(2) All required information will be recorded on the original copy of DA Form 4970 and forwarded to the AFIP for record keeping, regardless, if local physicians determine eligibility for training and testing. The original copy will be processed by ADP optical readers which will be utilized for timely processing and recording of all data. The process for decisionmaking is outlined within this section. It is sufficiently straightforward to permit local determination with assistance from the references cited at paragraph g(3)(b) below.

(3) The cardiovascular screening program is designed for integration with the periodic medical examination. Mass screening will not be done because the quality of the screening examination will suffer and mass screening will overload the medical system. Local commanders will have latitude in increasing the number of physicals done in the examining station, where feasible, and thus accelerate the completion of the screening. Commanders are reminded that medical examination and followup screening specialty clinics cannot handle excessive screening loads while continuing to support the medical care mission.

d. Screening instructions.

(1) The cardiovascular screen will be based on the 7 risk factors taken from The Framingham Study. Virtually all of these risk factors are now being measured in the routine periodic medical examination. The 7 risk factors will be used to calculate a risk factor index as outlined by the American Heart Association Publication 70-003-A Coronary Risk Handbook. A risk factor index of 5% or greater likelihood of developing coronary heart disease in 6 years will require the member to undergo further medical testing within regular medical channels before clearance is given for participation in the program.

(2) Three additional related factors will be addressed at the time of the initial examination: positive clinical cardiovascular (CV) history or physical findings, any abnormality of the ECG, and fasting blood sugar of 115 mg % (mg/dl) or greater. Thus a CV risk factor index of 5% or greater, positive CV history or physical finding, any abnormality of the ECG, or a fasting blood sugar of 115 mg % (mg/dl) or greater will require further medical testing before clearance is given for this program. Personnel with a CV risk index under 5%, negative CV history and physical examination, no abnormality of the ECG and a fasting blood sugar under 115 mg % (mg/dl) will be cleared to enter this program without further medical attention.

(3) The value obtained for all factors measured will be entered on DA Form 4970 and mailed within 3 days after testing is completed to the Armed Forces Institute of Pathology, ATTN: Department of Cardiovascular Pathology, 14th and Alaska Avenue, NW, Washington, DC 20306. The AFIP will record the data and calculate a supplemental risk index. The risk index and recommendations for subsequent action will be typed in the AFIP only section of the form and returned to the medical examining facility to assist in decisionmaking. DA Form 4970 with clearance for the Over-40 Fitness Program will be filed in the member's health record. Notification of clearance will then be made by the physical examination section to the individual's personnel records manager, the unit commander and the service member.

(4) When an individual is not cleared on an initial screen, further medical or cardiovascular consultation is required. The examining facility will then instruct the service member on the requirement for additional evaluation and assist in scheduling the consultant appointment. If the secondary screen results in clearance of the member, the consultation returned to the medical examining facility will contain that recommendation. The medical examining facility will notify the member's personnel officer that clearance has been given for the member to begin training. If consultation finds clearance cannot be given, the consulting physician will include that recommendation on the consult form and return it to the medical examining facility. The consulting physician will advise an individualized exercise program and other measures based upon his clinical judgment.

(5) When the secondary screen results in clearance for participation in

the program, the medical examining facility will enter the result in the space prepared by AFIP on DA Form 4970 and return the form to AFIP by mail for entry into the computer and subsequent return to the originating facility. The personnel records manager, unit commander, and the individual will be informed of clearance for participation in the program by the physical examination section. When further medical evaluation results in non-clearance, the medical examining facility conducting the examination will again enter the result on DA Form 4970 and return the form to AFIP. After the form is returned by the AFIP, the examining facility will file it in the medical record and accomplish the notification procedure established above.

e. Details for the medical screening examination.

(1) The medical screening examination can be done by the health care professional now performing the periodic medical examinations. All data items, including those not now a part of SF Forms 88 (Report of Medical Examination) and 93 (Report of Medical History), will be entered on DA Form 4970 (see fig. 10-4). This form is designed for ADP optical reader processing and must be completed in accordance with the coding instructions on the form. Information must be complete and accurate. Medical examining facilities will not hold completed forms for bulk mailing since this would defeat the purpose of graduated screening and cause undue delays in implementation of the screening as well as clearance of individuals for entry into the program.

f. Instructions for completing DA Form 4970.

(1) Enter the date examination is completed; e.g., 11 Feb 81.

(2) Enter examining facility MTF code; e.g., 1001.

(3) Patients name; e.g., Doe, John P.

(4) Social security account number without dashes; e.g., 462621593.

(5) The next seven items are the Framingham Factors and are explained as follows:

(a) Sex: Enter M for male or F for female.

(b) Age: Enter years only as of last birthday; e.g., 40.

(c) Smoking history: Enter average number of cigarettes per day; e.g., 40. If the individual does not smoke cigarettes or smokes a pipe, cigars or chews tobacco enter 0. (For the purpose of local calculation, less than 10 cigarettes per day average will be considered a negative smoking history.)

(d) Blood Pressure: Blood pressure should be taken in a quiet place after member has relaxed and is sitting comfortably with upper arm at heart level. Enter systolic and diastolic pressures in millimeters of mercury; e.g., 120/80.

(e) Electrocardiogram: A standard 12 lead scalar resting electrocardiogram will be taken and interpreted according to the routine in each examining facility. Left ventricular hypertrophy will be diagnosed only if definite criteria are present. The criteria of Romhilt and Estes or computerized ECG (CAPOC) criteria for definite LVH will obtain. Borderline and/or suggestive findings will not be counted as abnormalities. Entries will be made as follows: NL= Normal; LVH= Left Ventricular Hypertrophy only; ABN= Abnormalities other than LVH; LVH + ABN= LVH plus other abnormalities.

(f) Serum cholesterol: The blood will be drawn in the fasting state at least 12 hours after the last meal which should be of lowfat content and analyzed by the method standard for that examining facility. The reported value (mg% or mg/dl) will be entered; e.g., 271.

(g) Fasting blood sugar: The blood will be drawn in the fasting state at least 12 hours after the last meal and analyzed by the method standard for that examining facility. It is suggested that elevated values be followed up by telephone locally to insure the individual was fasting and by a repeat determination if necessary. The reported value (mg % or mg/dl) will be entered here; e.g., 109.

(h) Accuracy of laboratory determinations is critical to the safety of this program. The cholesterol values in the Coronary Risk Handbook are based on the Abell-Kendall Method. Individual laboratories must use a factor to correct their cholesterol determinations to the Abell-Kendall values. Guidance on value correction methodology for the purpose of standardization of cholesterol and quality assurance of glucose determinations will be obtained from the servicing Regional Medical Center or military reference laboratory (e.g., 10th Med Lab). Blood sugar must be based on true blood glucose level.

(i) Cardiovascular history and physical findings:

1 This item will be marked abnormal if any of the following is found on history or physical examination:

a Angina pectoris or suspicious chest discomfort.

b Dyspnea.

c Syncope.

d Precordial palpitation.

e Prior diagnosis of hypertension or treatment of hypertension; history of myocardial infarction.

f Significant cardiovascular physical finding (e.g., pathologic murmur or bruit, cardiomegaly, pathologic heart sound such as third sound, etc.).

g Any other clinical cardiovascular finding which is significant in the judgement of the examiner.

2 Any abnormality of the electrocardiogram: The Framingham Study identified only left ventricular hypertrophy as an ECG risk factor. For the purpose of this screening examination, any definite abnormality of the electrocardiogram will result in non-clearance and require further medical testing. The electrocardiogram results have already been entered above.

3 Fasting blood sugar: An elevated fasting blood sugar is a risk factor which results in elevation of the risk index. For the purpose of this medical screening examination, a blood sugar of 115 mg % (mg/dl) or greater will be considered abnormal and result in non-clearance and require further medical testing regardless of the risk index. The blood sugar has already been entered above.

(j) The examining facility must provide the complete return address in the space provided on the reverse side of the form.

g. Directions for further medical testing of those not cleared by the initial screening medical examination:

(1) When non-clearance on the initial screen is entered on DA Form 4970 for any reason, the AFIP will return the form to the originating medical examining facility with a draft consultation sheet (SF 513) accompanying the form to assist the examining facility in the administrative workload. The form will then be forwarded for consultation and further examination by an internal medicine specialist or cardiologist. The member will be notified of time and place for the consultation appointment. Since an exercise tolerance test will customarily be part of this consultation, the member will be directed to report appropriately prepared (e.g., fasting, in comfortable running attire including foot gear, and to anticipate a change of clothing before return to duty).

(2) The medical examining facility must provide the consultant with the following:

(a) Member's individual health record.

(b) DA Form 4970.

(c) The X-ray jacket including the chest X-ray made in conjunction with the current periodic examination.

(d) Consultation sheet, SF 513.

(3) The consultation (secondary screen) should include the following:

(a) An independent history and medical examination recorded on SF 513.

(b) A maximum symptom limited exercise tolerance test after appropriate informed consent. The techniques and criteria contained in the following American Heart Association publications should be helpful: Pub #70-041-A, The Exercise Standards Book; Pub #70-008-A, Exercise Testing and Training of Apparently Healthy Individuals; Pub #70-008-B, Exercise Testing and Training of Individuals with Heart Disease or at High Risk for its Development; and Pub #70-003-A, Coronary Risk Handbook. (These publications have been distributed to all medical examining facilities.)

(c) Fluoroscopy of the heart for intracardiac calcification, particularly coronary artery calcification if feasible.

(4) If these procedures result in negative or nonremarkable findings, the member should be cleared by the consulting physician. The consultation form will be returned to the originating medical examining facility and filed in the individual's health record. DA Form 4970 will be annotated in the space printed in the AFIP only section and returned to the AFIP where this information will be entered into the computer. The form will then be returned to be filed in the individual's health record.

(5) When one or more of the above procedures are positive or the consulting physician is of the opinion that the member has medical contraindications to routine entry into this program, further testing such as stress thalium testing, coronary angiography, etc., may be in order. In this instance, a medical follow-up program will likely be indicated and a special individualized exercise program based on the safe exercise level achieved on the exercise tolerance test should be prescribed, if medically feasible. The guidance in the American Heart Association publications mentioned earlier will be helpful in this regard. In this instance, the consultation and DA Form 4970 will also be completed and returned to the originating medical examining facility. The DA Form 4970 will be returned to AFIP where the data will be entered into the computer. DA Form 4970 will then be returned to the examining facility to be filed along with the consultations in the health record. In each case the examining facility will notify the personnel records management officer of final clearance or non-clearance for the Over-40 Physical Fitness Program.

h. Notification of results. The medical examining facility is responsible

for notifying the member's command and the personnel records manager of the final status and clearance or non-clearance for the program.

i. Point of contact. For questions regarding this program contact COL Bedynek or MAJ Broadway, DASG-PSC, Autovon 227-8394.

Page A2-1, Appendix II, Tables of Acceptable Audiometric Hearing Level. Table III, Acceptable Audiometric Hearing Level for Admission to the US Military Academy, (ANSI 1969) (Unaided Acuity), is superseded as follows:

Table III. Acceptable Audiometric Hearing Level for Admission to US Military Academy, ISO--1964 (ANSI 1969) (Unaided Acuity)

Cycles per Second (Hz)	Each ear
250	No requirement
500	30 dB
1000	25 dB
2000	25 dB
3000	No requirement
4000	45 dB
6000	No requirement
8000	No requirement

Pages A8-1 and A8-2. Appendix VIII, Physical Profile Functional Capacity Guide. Column H, Hearing--Ears, is superseded as follows:

Profile serial	H Hearing--Ears
1----------	Audiometer average level each ear not more than 27 dB at 500, 1000, 2000 Hz; not over 45 dB at 4000 Hz.
2----------	Audiometer average level not more than 31 dB at 500, 1000, 2000 Hz and 55dB at 4000 Hz in both ears, or 30 dB at 500 Hz and 25 dB at 1000 and 2000 Hz and 35 dB at 4000 Hz in the better ear.
3----------	May have hearing level at 30 dB with hearing aid by speech reception score, or acute or chronic ear disease not falling below retention standards (with hearing aid only); may have

	speech reception threshold level of 30 dB with hearing aid set at "comfort level" (i.e., adjusted to 50 dB HL speech noise), or acute or chronic ear disease not falling below retention standards.
4----------	Below retention standards. Auditory acuity, and organic disease of the ears.

NOTE: The odd numbers 27 dB and 31 dB reflect averaging of ASA to ISO.

Pages A9-3, A9-5 and A9-7. Appexdix IX, Scope and Recording of Medical Examinations.

Items 32, 45, 50, 56 and 69 are superseded as follows:

Item SF 88	Types of examinations A	Types of examinations B	Explanatory notes	Model entries
32	X	X	Digital rectal required for all periodic examinations of Active Army members regardless of age. A definite statement will be made that 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.
45A	X	X	Identify tests used and record results.	
B	X	X	Items A and D not routinely required for	
C	X	X	Type A medical examinations accomplished	
D	X	X	for initial entrance or for routine separation. Must be accomplished for all Type B examinations and for periodic and retirement examinations of Active Army members.	
50	X	X	Mammography--After age 50 during periodic examination of Active Army women.	Identify test(s) and record results.
	X	X	White Blood Cell Count--All marine divers	
	X	X	Hematocrit--Required for periodic and separation examinations for Active Army members.	
	X	X	Stool Guaiac--Same as Hematocrit above.	
	X	X	Cholesterol--Same as Hematocrit above.	
	X	X	Triglycerides--Same as Hematocrit above.	
	X	X	Fasting Blood Sugar--Same as Hematocrit above.	
56	(*)	X	*Only if indicated. Record in degrees Fahrenheit to the nearest tenth.	98.6°
69	(*)	(*)	*Only if indicated.	
			Tonometry--Required for periodic examinations of Active Army members age 40 and over.	
			Tonometry--Required for all ATC personnel regardless of age.	
			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.

THIS FORM WILL BE READ BY A MACHINE — PLEASE READ AND FOLLOW DIRECTIONS BELOW

MEDICAL SCREENING SUMMARY — OVER-40 PHYSICAL FITNESS PROGRAM

For use of this form, see AR 40-501, 102, the proponent agency is the Office of The Surgeon General.

1. DATE OF EXAM (dd mmm yy) 27 FEB 81	2. MTF CODE 1001	3. PATIENT'S NAME (Last, First, MI) Harrison, Benjamin F.	4. SSN 123456789
5. SEX (M=Male, F=Female) M	6. AGE (Current birthday) 42	7. SMOKING HISTORY (Average number cigarettes per day) 40	8. BLOOD PRESSURE (XXX/XXX mm Hg) 120/100
9. ELECTROCARDIOGRAM (NL=Normal, LVH=Left Ventricular Hypertrophy Only, ABN=Abnormalities other than LVH, LVH + ABN=LVH plus other abnormalities) LVH + ABN			10. SERUM CHOLESTEROL (XXX mg %) 102
11. FASTING BLOOD SUGAR (XXX mg %) 103		12. CARDIOVASCULAR HISTORY AND PHYSICAL (NL=Normal, ABN=Abnormal) ABN	

SAMPLE

FOR AFIP USE ONLY

CODING INSTRUCTIONS

Typewriter setting: 10 Pitch - double space. Use only "OCR-b" typing element, with high yield carbon ribbon. Type only in spaces provided, using specified codes where indicated. After completion, mail to THE ARMED FORCES INSTITUTE OF PATHOLOGY, ATTN: Dept. of Cardiology, 14th & Alaska Ave., N.W., Washington, DC 20306. Type YOUR return address on reverse side of this form in area indicated.

Figure 10-4. Sample DA Form 4970, Medical Screening Summary--Over-40 Physical Fitness Program.

24 March 1981 I02, AR 40-501
(DASG-PSP-O)
By Order of the Secretary of the Army:

E. C. MEYER
General, United States Army
Chief of Staff

Official

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

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☆U.S. GOVERNMENT PRINTING OFFICE: 1981—341-661:1401

Reference

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 23 January 1981

Immediate Action
INTERIM CHANGE

AR 40-501
INTERIM CHANGE
NO. I01
Expires 23 January 1982

MEDICAL SERVICES

STANDARDS OF MEDICAL FITNESS

This interim change is forwarded to the field to supersede appendix II, Tables of Acceptable Audiometric Hearing Level; and the Hearing--Ears column in appendix VIII, Physical Profile Functional Capacity Guide. The change will replace the hearing standards in the appendixes established by Change 32. This change will correct erroneous hearing standards previously published. This interim change expires 1 year from date of publication and will be destroyed at that time unless sooner superseded by a formal printed change; is being distributed by first class mail through the publications pinpoint distribution system to all holders of AR 40-501; is an interim measure, issued in other than page-for-page format; and will be superseded by Change 33, AR 40-501.

Page A2-1. Appendix II, Tables of Acceptable Audiometric Hearing Level, is superseded as follows:

APPENDIX II

TABLES OF ACCEPTABLE AUDIOMETRIC HEARING LEVEL

Hearing of all applicants for appointment, enlistment or induction will be tested by audiometers calibrated to the International Standards Organization (ISO - 1964 (ANSI 1969)).

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

Table I. Acceptable Audiometric Hearing Level for Appointment, Enlistment and Induction
ISO - 1964 (ANSI 1969)

Cycles per second (Hz)	Both ears
500	Average of the 6 readings (3 per ear) in the speech frequencies not greater than 30 decibels with no level greater than 35.
1000	
2000	
4000	55 (each ear).

This publication may be released to foreign governments (sec 1719, title 44, US Code).

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Table I. Acceptable Audiometric Hearing Level for Appointment, Enlistment and Induction
ISO - 1964 (ANSI 1969)--Continued

OR

If the average of the three speech frequencies is greater than 30 decibels ISO, reevaluate the better ear only in accordance with the following table of acceptability:

Cycles per second (Hz)	ISO
500	30 dB
1000	25 dB
2000	25 dB
4000	35 dB

The poorer ear may be totally deaf.

Table II. Acceptable Audiometric Hearing Level for Army Aviation Including Air Traffic Controllers
(ANSI 1969)(Unaided Acuity)

Frequency (Hz)		500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz
Classes 1 & 1A	Each ear	25	25	25	35	45	45
Class 2 (Aviators)	Better ear	25	25	25	35	65	75
	Poorer ear	25	35	35	45	65	75
Class 2 (Air Traffic Controllers)	Each ear	25	25	25	35	65	75
Class 3	Each ear	35	30	30	55	55	55

Table III. Acceptable Audiometric Hearing Level for Admission to US Military Academy
(ANSI 1969)(Unaided Acuity)

Frequency (Hz)	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz
EACH EAR	25	25	25	55	55	55

Pages A8-1 and A8-2. Column H, Hearing--Ears, appendix VIII, Physical Profile Functional Capacity Guide, is superseded as follows:

APPENDIX VIII

PHYSICAL PROFILE FUNCTIONAL CAPACITY GUIDE

Profile serial	H Hearing--Ears
1----------	Audiometer average level each ear not more than 15 dB @ 500, 1000, 2000 Hz. Not over 40 dB at 4000 Hz.
2----------	Audiometer average level not more than 20 dB @ 500, 1000, 2000 Hz and 50 dB at 4000 Hz in both ears, or 15 dB at 500, 1000, 2000 Hz and 30 dB at 4000 Hz in better ear.

APPENDIX VIII

PHYSICAL PROFILE FUNCTIONAL CAPACITY GUIDE--Continued

Profile serial	H Hearing--Ears
3----------	May have hearing level at 20 dB with hearing aid by speech reception score, or acute or chronic ear disease not falling below retention standards.
4----------	Below Retention Standards. Auditory acuity, and organic disease of the ears.

(DASG-PAP)

By Order of the Secretary of the Army:

E. C. MEYER
General, United States Army
Chief of Staff

Official:

J. C. PENNINGTON
Major General, United States Army
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AR 40-501
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HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 21 August 1979

Immediate Action
INTERIM CHANGE

AR 40-501
INTERIM CHANGE
NO. I01
Expires 21 August 1980

S/S CH 32 15 Aug 80 Rec'd 10 Sept 79

MEDICAL SERVICES

STANDARDS OF MEDICAL FITNESS

This interim change modifies procedures for scheduling separation/retirement medical examinations. It expires 1 year from date of publication and will be destroyed at that time unless sooner superseded by a formal printed change; is being distributed by 1st class mail through the publications pinpoint distribution system to all holders of AR 40-501; is, as an interim measure, issued in other than page-for-page format; and will be included in the formal printed change to AR 40-501.

Page 10-11, paragraph 10-25, is superseded as follows:

10-25. Separation. a. There is no statutory requirement for all Regular Army (including USMA cadets) and US Army Reserve members to undergo a medical examination incidental to separation or retirement from active Army service; however, it is Army policy to accomplish a medical examination if the separating or retiring member requests it. The following schedule of separation/retirement medical examinations is established:

	Medical Examination		
	Required	Not Required	Can Be Requested By Member (In Writing)
Retirement after 20 or more years of active duty.		X	X
Retirement from active service for physical disability, permanent or temporary, regardless of length of service.	X		
Expiration of term of active service (Separation or discharge, less than 20 years of service) (RA and USAR).		X	X
Upon review of Health Record, evaluating physician at servicing MTF determines that, because of record of medical care received during active service, medical examination will serve best interests of member and Government, e.g., hospitalization for other than diagnostic purposes within 1 year of anticipated separation date.	X*		

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	Medical Examination		
	Required	Not Required	Can Be Requested By Member (In Writing)
Individual is member of Army National Guard and has been on active duty or active duty training (10 USC 3502).	X*		
Deserters who return to military control and are being processed for administrative or judicial discharge.	X*		
Prisoners of war, including internees and repatriates, undergoing medical care, convalescence or rehabilitation, who are being separated.	X*		
Officers, WOs and EM previously determined eligible for separation or retirement for physical disability but continued on active duty after complete physical disability processing (Chap 6, AR 635-40 and predecessor regulations).	X (Plus MEB and PEB)		
Officers, WOs and EM previously processed for physical disability (AR 635-40) and found fit for duty with one or more numerical permanent designators "4" in physical profile serial.	X*		
All officers, WOs and EM with one or more temporary numerical designators "4" in physical profile serial.	X*		
Officers and WOs being processed for separation under provisions of Secs XV, XIX, XXVIII of Chap 3, and Sec IV of Chap 5, AR 635-100; Chaps 4, 5, 7, 10, 12, 16, AR 635-120.	X*		
Officers and WOs being separated under provisions of AR 635-100 and AR 635-120 other than listed.		X	X
Enlisted members being processed for separation under provisions of paras 5-3, 5-6 and 5-14 of Chap 5, Sec III of Chap 8, Chap 9, Chap 13, para 14-23 Sec IV of Chap 14, AR 635-200.	X*		
Enlisted members being processed for separation under provisions of Chap 10, and Sec V of Chap 14, AR 635-200. (Mental evaluation only is required. Medical examination may be requested by member in writing).	X*		

	Medical Examination		
	Required	Not Required	Can Be Requested By Member (In Writing)
Discharge in absentia (Officers and EM):			
Civil confinement		X	
When BCD or DD is upheld by appellate review and individual is on excess leave.		X	
Deserters who do not return to military control.		X	
Enlisted personnel being processed for separation under all other provisions of AR 635-200 not listed above.		X	X

*Examinations will be accomplished not earlier than 4 months or later than 1 month prior to scheduled date of discharge, relief from active duty or active duty for training.

b. When accomplished voluntarily or involuntarily, a medical examination is intended to identify conditions that may require attention. It is not accomplished to determine eligibility for physical disability processing although such could occur as a result of examination findings.

c. Voluntary requests for medical examinations will be submitted to the commander of the servicing medical treatment facility (MTF) not earlier than 4 months nor later than 1 month prior to the anticipated date of separation/retirement. MTF commanders will not request a delay in administrative processing unless physical disability consideration (Medical Board referral to a Physical Evaluation Board) is deemed appropriate. Commanders/MILPOs of members of the ARNG, and all other members who require a medical examination as indicated above, will schedule those examinations with MTF commanders in time to assure completion of the examination not later than 72 hours prior to anticipated separation date. (Close coordination between CDRs/MILPOs and MTF CDRs is required to assure timely scheduling and completion of the required examinations.)

d. Members who have been in medical surveillance programs because of hazardous job exposure will have a clinical evaluation and specific laboratory tests accomplished prior to separation even though a complete medical examination may not be required.

(DASG-PSP)

By Order of the Secretary of the Army:

E. C. MEYER
General, United States Army
Chief of Staff

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Major General, United States Army
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Reference

29 Jan 74 AR 40-501

JOINT MESSAGEFORM

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BOOK

MESSAGE HANDLING INSTRUCTIONS

Bul 13 26 Mar 73

FROM: DA //DAPE-MPE//

TO: ALL HOLDERS OF ID COPIES OF AR 40-501, STANDARDS OF MEDICAL FITNESS

Rec'd 3/13/73

UNCLAS

SUBJECT: CHANGE TO AR 40-501

1. THIS CHANGE IS BEING DISTRIBUTED THROUGH PUBLICATIONS PINPOINT DISTRIBUTION SYSTEM TO ALL HOLDERS OF AR 40-501.

2. CHANGE TO AR 40-501 IS NOW BEING PROCESSED FOR PUBLICATION IN THE NEAR FUTURE. THE CHANGE REFLECTS NEW AND SIGNIFICANT CHANGES TO THE PRESENT SYSTEM REGARDING DISABILITY SEPARATION AND RETIREMENTS.

3. THIS MESSAGE PROVIDES EARLY INFORMATION FOR USERS OF AR 40-501 REGARDING THE CHANGES WHICH ARE TO BE IMPLEMENTED UPON RECEIPT OF THIS MESSAGE.

4. AR 40-501 IS CHANGED AS FOLLOWS. CHANGE PARAGRAPHS NOTED TO READ AS FOLLOWS:

A. PARAGRAPH 3-3A – 3-3 POLICIES. "NORMALLY, MEMBERS WITH CONDITIONS LISTED IN THIS CHAPTER WILL BE CONSIDERED UNFIT BY REASON OF PHYSICAL DISABILITY; HOWEVER, THIS CHAPTER PROVIDES

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REPLACES DD FORM 173, 1 JUL 68, WHICH WILL BE USED.

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. WHEN A MEMBER IS BEING PROCESSED FOR SEPARATION FOR REASONS OTHER THAN PHYSICAL DISABILITY, HIS CONTINUED PERFORMANCE OF DUTY UNTIL HE IS SCHEDULED FOR SEPARATION FOR OTHER PURPOSES CREATES A PRESUMPTION THAT THE MEMBER IS FIT FOR DUTY. EXCEPT FOR A MEMBER WHO WAS PREVIOUSLY RETAINED IN A LIMITED ASSIGNMENT DUTY STATUS, SUCH A MEMBER SHOULD NOT BE REFERRED TO A PHYSICAL EVALUATION BOARD UNLESS HIS PHYSICAL DEFECTS RAISE SUBSTANTIAL DOUBT THAT HE IS FIT TO CONTINUE TO PERFORM THE DUTIES OF HIS OFFICE, RANK, GRADE OR

RATING. 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 MEMBER'S REPORT OF MEDICAL EXAMINATION."

B. PARAGRAPH 3-3B - "THE VARIOUS MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH MAY RENDER A MEMBER UNFIT TO PERFORM THE DUTIES OF HIS OFFICE, GRADE, RANK OR RATING 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 UNABLE 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, OR

(2) THE INDIVIDUAL'S HEALTH OR WELL-BEING WOULD BE COMPROMISED IF HE WERE TO REMAIN IN THE MILITARY SERVICE, OR

(3) IN VIEW OF THE MEMBER'S PHYSICAL CONDITION, HIS RETENTION IN THE MILITARY SERVICE WOULD PREJUDICE THE BEST INTERESTS OF THE GOVERNMENT (E.G., A CARRIER OF COMMUNICABLE DISEASE WHO POSES A THREAT TO OTHERS).

C. PARAGRAPH 3-3I - "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 BE CONSIDERED PRESUMPTIVE EVIDENCE OF PHYSICAL FITNESS. EXCEPT FOR A MEMBER WHO WAS PREVIOUSLY RETAINED IN A LIMITED ASSIGNMENT DUTY STATUS, SUCH A MEMBER SHOULD NOT BE REFERRED TO A PHYSICAL EVALUATION BOARD UNLESS HIS PHYSICAL DEFECTS RAISE

SUBSTANTIAL DOUBT THAT HE IS FIT TO CONTINUE TO PERFORM THE DUTIES OF HIS OFFICE, GRADE, RANK AND RATING."

D. PARAGRAPH 3-36C - "MISCELLANEOUS CONDITIONS AND DEFECTS. CONDITIONS AND DEFECTS, INDIVIDUALLY OR IN COMBINATION, IF

(1) THE INDIVIDUAL IS UNABLE 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, OR

(2) THE INDIVIDUAL'S HEALTH OR WELL-BEING WOULD BE COMPROMISED IF HE WERE TO REMAIN IN THE MILITARY SERVICE, OR

(3) IN VIEW OF THE MEMBER'S PHYSICAL CONDITION, HIS RETENTION IN THE MILITARY SERVICE WOULD PREJUDICE THE BEST INTERESTS OF THE GOVERNMENT (E.G., A CARRIER OF COMMUNICABLE DISEASE WHO POSES A HEALTH THREAT TO OTHERS). SUBJECT TO THE LIMITATIONS SET FORTH IN PARAGRAPH 3-3I OF THIS REGULATION, QUESTIONABLE CASES INCLUDING THOSE INVOLVING LATENT IMPAIRMENT AND/OR THOSE WHEN NO SINGLE IMPAIRMENTS MAY BE CONSIDERED TO RENDER THE INDIVIDUAL UNFIT WILL BE REFERRED TO PHYSICAL EVALUATION BOARDS."